Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 28, 2023

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

RE: CCN: 245055
Cycle Start Date: June 29, 2023

Dear Administrator:

On June 29, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 29, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 29, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/26/23 to 6/29/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop	E 004		9/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review the Emergency Action Plan (EAP) annually in accordance with the requirements of CFR 483.73. This had the potential to affect all 206 residents currently residing in the facility and all staff and visitors to the facility. Findings include:	E 004	Signature page showing review of emergency plan will be added. Emergency plan will be reviewed. Administrator and Maintenance Director received re-education on the necessity to review and update EAP annually. Administrator/Designee will be	

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E 004	Continued From page 2 Review of the facility EAP lacked a signature page or other indication it had been reviewed in the previous year. Further, no documentation was provided to indicate the plan was revised based on review of the plan or that upon review of the plan no revision was needed. During an interview on 6/29/23 at 9:00 a.m., the director of maintenance (DMT) stated he had not reviewed the facility EAP in the previous year and was unaware if anyone else had. The DMT verified there was no signature page to indicate the EAP had been reviewed nor anything in the EAP that was dated within the previous year to indicated it had been reviewed or revised. The DMT further stated he was responsible for reviewing and updating the EAP as necessary.	E 004	responsible for ensuring compliance by random weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		9/1/23

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E 041	Continued From page 3 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource	E 041		

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E 041	Continued From page 4 Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	E 041	The Generator will be tested for 4 hours.	

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E 041	Continued From page 5 and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2.1, 8.4.2.3, 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: During interview and document review on 06/28/2023 between 09:00 a.m. and 01:30 p.m., it was revealed by a review of available documentation that at the time of the survey the Maintenance Director was unable to tell me what the size of his generator was, and he did not know what 30% load of his generator was. Since I could not tell what the 30% load of the generator was I was unable to know if he was running the generator at 30% each month, and he did not have an annual load bank completed. During document review on 06/28/2023 between 09:00 a.m. and 01:30 p.m., it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility's Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	E 041	The documentation will be made available. Administrator and Maintenance Director received re-education on the generator requirements. Administrator/Designee will be responsible for ensuring compliance by random weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	
F 000	INITIAL COMMENTS On 6/26/23 to 6/29/23, a standard recertification	F 000		

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F 000	Continued From page 6 survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H50553035C (MN84301), H50553036C (MN87019), H50553038C (MN84903 and MN84904), H50553039C (MN86469), H50553085C (MN94583), and H50553086C (MN94578). The following complaints were reviewed WITH deficiencies cited: H50553040C (MN84270), H50553041C (MN84272), H50553082C (MN84274), H50553083 (MN84276), H50553084 (MN86195) at F677, and H50553037C (MN85040) at F725. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561		9/1/23

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F 561	Continued From page 7 through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor a resident choice for a private room despite evidence that a private room would promote mental wellbeing for 1 of 1 resident (R191) reviewed for choices. Findings include: R191's quarterly Minimum Data Set (MDS) indicated R191 was cognitively intact and needed extensive assistance with all activities of daily living (ADLs).	F 561	R191 was moved to a private room per request on 7/6/23. Residents voicing preference for a private room will be referred to social services for evaluation and eligibility. Residents currently on the waitlist will be evaluated by social services. Social Workers/ Admission coordinator have been re-educated on process for	

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F 561	Continued From page 8 R191's Medical Diagnosis list, dated 2/10/23, indicated R191 had several medical diagnoses including adjustment disorder with anxiety (an emotional or behavioral reaction to a stressful event or change in a person's life) and depression. R191's progress notes indicated at least three occasions R191 expressed concern over moving to a shared room. On 5/5/23 it was documented by social services R191, "expressed concern, stating he does not want to be in a shared room". R191 also expressed concern that he did not feel, "medically stable" and believed a move may, "hinder his mental and physical health". On 5/12/23 it was documented by social services R191 was transferring to rooms on 5/16/23. R191 continued to express concern and confusion regarding the need for a room change and losing his private room. On 5/26/23 it was documented by social services R191 stated he would prefer a private room as the shared room was "stressful and anxiety provoking". R191's Associated Clinic of Psychology note, dated 5/24/23, indicated a private room would be of, "great value" to R191. The note also indicated the importance of following up on R191's request, such as a private room, to help R191 feel secure at the facility. During interview on 6/26/23 at 1:45 p.m., R191 stated he was stressed about his recent room	F 561	residents requesting private rooms. Director of Social Services/Designee will be responsible for ensuring compliance by auditing 3 residents with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 561	Continued From page 9 change from a private room to a shared room, stating his, "therapist tried to stop it, but it didn't work". During an interview on 6/28/23 at 12:21 p.m., the admission coordinator (AC) stated R191 would qualify for a private room based on his insurance but was not currently on the wait list. The AC stated nursing and social services would let her know if there was a nursing or psychosocial need for a resident to have a private room, further stating she was aware R191, "really, really wanted one (a private room)". During an interview on 6/29/23 at 11:00 a.m., the director of social services (DSS) stated she was aware R191 wanted a private room for his mental health, stating the facility had held off on getting R191 a roommate but he was getting a roommate that day. The DSS further confirmed R191 was not currently on the waitlist for a private room. During an interview on 6/29/23 at 4:07 p.m., R191 Doctor of Psychology (PsyD) stated R191 was "overly anxious" and had a "high need to be validated". The PsyD further stated putting R191 in a private room was important to help him feel validated. Facility policy on resident choices requested but not received.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		9/1/23

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F 580	Continued From page 10 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

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F 580	Continued From page 11 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to notify the medical provider of a significant change in condition for one resident (R-190) of five residents who were reviewed for unnecessary medications. Specifically, the facility failed to notify the medical provider when the resident had an increase in abnormal involuntary movements (AIMS) while taking two antipsychotic medications. Findings include: Review of an undated policy provided by the facility, titled "Change in Condition, revealed, "Lakehouse Healthcare promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status." Review of a policy provided by the facility, titled "AIMS Assessment," dated 02/10/16, indicated the facility was to "Notify the resident's physician/NP [Nurse Practitioner] of the initial AIMS score, and ongoing if there is a change in the resident's AIMS scores." Review of a document provided by the facility titled "Admission Record" indicated R190 was admitted to the facility on 11/28/22 with a diagnosis of dyskinesia (uncontrolled, involuntary	F 580	R190 cited has had change in AIMS status reported to provider per policy. AIMS completed over the past 30 days will be reviewed to ensure provider notified as appropriate. Licensed staff have been educated on AIMs assessments, identification of change, proper notification of provider and documentation. Director of Nursing/Designee will be responsible for ensuring compliance by audits of 5 residents x 4 weeks and Monthly x 2 to ensure appropriate notification was completed. Facility QA&A Committee will review audit results.	

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F 580	Continued From page 12 muscle movements. Causes of dyskinesia include antipsychotic medication side effects). Review of R190's "Clinical Physician Orders," located in the electronic medical record (EMR) under the "Orders" tab and dated 12/13/22, indicated the resident was prescribed Seroquel (an antipsychotic0 12.5 milligrams (mg) two times per day for dementia with psychosis. On this same date, the resident was also prescribed Zyprexa (a different antipsychotic) 2.5 mg to be administered at bedtime for dementia with psychosis. Review of R190's "AIMS," dated 03/30/23, located under the "Assmnts [Assessment]" tab in the EMR revealed the resident scored seven, indicating detectable abnormal movements. Review of R190's "AIMS," dated 06/21/23, located under the "Assmnts" tab in the EMR revealed the resident scored 11, which indicated a significant increase in involuntary movements. Review of R190's entire EMR revealed no evidence that the physician or NP were notified when the facility identified that R190 had experienced a change in condition that could require medical intervention (significant increase in involuntary movements). During an interview on 06/29/23 at 12:50 p.m., clinical manager (CM)-B stated the AIMS score increase from seven to 11 would be a significant change in R190's condition and the physician should have been notified. During interview on 06/29/23 at 1:10 p.m., with Licensed Practical Nurse (LPN) C revealed she	F 580		

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F 580	Continued From page 13 was the staff member who completed both AIMS evaluations for R190. LPN-C stated she believed she notified a medical provider regarding the increase in involuntary movements made by the resident. LPN-C stated the resident had an increase in tics, tongue thrusting and other movements and confirmed this information was not documented. During an interview on 06/29/23 at 2:29 p.m., nurse practitioner (NP)-H stated he was not aware of the increase in R190's AIMS score and should have been notified. NP-H confirmed this would be considered a change in the resident's condition. During an interview on 06/29/23 at 2:52 PM, the Director of Nursing (DON) stated her expectation, that, based on the increase in AIMS for R190, the physician should have been notified.	F 580		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and document review, the facility failed to ensure there were physician orders upon admission for all necessary care for one resident (R-565) of 35 sampled residents. The facility failed to ensure that there were PICC (Peripherally inserted central catheter) line dressing orders prior to changing R565's PICC line dressing.	F 635	R565 had dressing changed on 6/27/23 and order entered into the EMR for ongoing weekly dressing changes per policy. R565 has discharged from the facility. Residents with IV access orders will be checked to ensure that dressing changes	9/1/23

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F 635	Continued From page 14 Findings include: Review of a policy provided by the facility titled "Physician Orders. . .Patient Care Services," dated 01/03/14, indicated "Admission Orders from a Discharging Hospital. . .All signed physician orders, and pertinent medical information documented on the hospital transfer forms will be entered into the resident's EHR [electronic health record] by. . .licensed nurse." Review of R565's "Hospitalist Discharge Summary," dated 06/16/23, which was located under the "Misc [Miscellaneous] tab" in the electronic medical record (EMR), revealed R565 had septic arthritis of his hip. The discharge summary indicated the resident had surgery and required six weeks of antibiotics to be administered through a PICC line. Review of a document provided by the facility, titled "Admission Record," indicated R565 was admitted to the facility on 06/16/23 with diagnoses of perineal abscess and staphylococcus infection. with required antibiotics to be administered through a PICC line. Review of R565's "Clinical Physician Orders," located under the "Order" tab in the EMR revealed no evidence of an order for dressing changes around the resident's PICC line. During an interview on 06/26/23 at 2:50 p.m., R565 stated he received antibiotics through his PICC line and had a bone infection. The resident stated he was concerned the dressing on his PICC line was not changed on a regular basis. During this interview, the resident showed his arm, on which there was a dressing dated	F 635	orders are in place at the time of admission. Licensed staff and Health Unit Coordinators have been re-educated to ensure that appropriate dressing orders are entered upon admit for all residents with a central IV catheter. Director of Nursing/Designee will be responsible for ensuring compliance by checking IV orders of 5 residents with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 635	Continued From page 15 06/24/23. The dressing was peeling at the bottom. During an additional interview on 06/27/23 at 8:09 a.m., as R565 was walking towards the dining area, he still had on the same dressing that was dated 06/24/23. During an interview on 06/28/23 at 10:10 AM, registered nurse (RN)-A stated she was the Unit Manager for the second floor. RN-A confirmed there were no orders for PICC line dressings, and she recently entered the order for changing the dressing on 06/27/23 (after initiation of the survey). RN-A stated the physician order should have been entered on the day R565 was admitted to the facility. During an interview on 06/29/23 at 8:53 a.m., the director of nursing (DON) suggested that there might be standing orders for dressing changes on a PICC line. During an additional interview on 06/29/23 at 12:10 pm., DON confirmed there were no standing orders for PICC line dressing changes.	F 635		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		9/1/23

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F 676	Continued From page 16 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to provide routine baths and incontinence care to 1 of 1 resident (R92) reviewed for activities of daily living (ADLs). Findings include: R92's significant change Minimum Data Set (MDS), dated 4/18/23, indicted R92 was cognitively intact and required extensive assistance with transfers, bed mobility, dressing,	F 676	R92 will be interviewed regarding her toileting and shower preferences and assisted with ADL cares per care plan, including showering and toileting Resident's shower tasks over the last 30 days will be reviewed. Residents care plans for toileting will be reviewed.	

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F 676	Continued From page 17 toileting, and personal hygiene. R92's Care Plan, dated 11/4/22, indicated R92 preferred to take a shower every Thursday morning after breakfast with staff assistance. The care plan further indicated R92 was totally dependent on staff for toilet use, dated 4/15/23, and was to be toileted upon rising, after meals and at bedtime, dated 4/19/22. R92's bathing task in the electronic medical record (EMR) indicated R92 received only one shower during the month of June, occurring on 6/6/23. R92's toileting task in the EMR indicated R92 had been toileted on less than all three shifts, 20 times in the month of June. During an interview on 6/27/23 at 9:08 a.m., R92 stated staff forgot to shower her on several occasions and that she had gone to bed with a wet brief numerous times when staff did not assist her with toileting before bed. R92 further stated she tried not to drink too much during the day so she wouldn't be, "sitting in a wet brief all day". During an interview and observation on 6/28/23 at 9:31 a.m., nursing assistant (NA)-F stated R92 needed assist of one staff member to transfers and was totally dependent on staff for toileting. NA-F was observed placing a sheet on the seat of R92's wheelchair and stated R92 usually leaks urine through her brief onto the wheelchair so a sheet was used to help protect the wheelchair seat. NA-F further stated toileting and bathing gets documented under tasks in the EMR.	F 676	Licensed and unlicensed nursing staff have been re-educated to ensure services are provided in accordance with each resident□s plan of care. Director of Nursing/Designee will be responsible for ensuring compliance by looking at 5 residents randomly with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 676	Continued From page 18 During an interview on 6/29/23 at 8:43 a.m., licensed practical nurse (LPN)-F stated the NAs do not usually let the nurses know if a bath is missed and the nurses often have to ask or they are unaware if a resident's bath was completed. During an interview on 6/29/23 at 8:55 a.m., registered nurse (RN)-H stated she would expect the nurses and NAs to follow the care plan, to include toileting and bathing schedules. During an interview on 6/29/23 at 12:55 p.m., the director of nursing (DON) stated the nurse managers on the units handled missed or refused baths, but she would expect that baths are getting done at least weekly and are being documented in the EMR. A facility policy titled Grooming/Hygiene Care Patient Care Services, dated 4/4/2005 indicated, "resident grooming will be performed".	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide weekly baths to 1 of 1 resident (R11) reviewed for activities of daily living (ADL). Findings include: R11's quarterly Minimum Data Set (MDS) dated	F 677	R11 will be assisted with ADL cares per care plan, including showering. Residents shower tasks over the last 30 days will be reviewed. Licensed and unlicensed nursing staff have been re-educated to ensure services	9/1/23

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F 677	Continued From page 19 3/23/23, indicated R11 had intact cognition, required supervision with eating, and extensive assistance for all other activities of daily living (ADLs). R11's diagnoses included major depression, bipolar disorder, anxiety, suicidal ideations, obesity, overactive bladder, cataracts, hoarding disorder, diabetes, venous insufficiency (decreased circulation to the arms and legs), rectal prolapse, and psoriasis (a skin disease causing itchy, scaly patches). R11's Care Area Assessment (CAA) dated 6/24/22, indicated R11 triggered for visual function, communication, indwelling catheter, and pressure ulcers. R11's care plan undated, indicated R11 had an ADL self-care deficit related to increased pain, venous insufficiency, depression, and diabetes and bowel incontinence related to decreased physical functioning. Interventions included bathing/showering with an assist of one staff member every Monday AM. R11 also had a behavior issue with interventions that included providing consistent care. R11 also had impairment to her skin related to current and chronic vascular wounds. Interventions included keeping skin clean and dry. R11's orders dated 6/13/22, indicated R11 was to have vital signs and a body audit completed every Monday AM on shower day. Review of the facility bath schedule dated 3/17/23, indicated R11 was to receive a bath every Monday morning. Review of R11's bath log dated June 2023, indicated R11 received a bath on 6/12/23 and	F 677	are provided in accordance with each resident□s plan of care. Director of Nursing/Designee will be responsible for ensuring compliance by looking at 5 residents randomly with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 677	Continued From page 20 6/19/23. The log further indicated "Not Applicable" on 6/26/23. R11's progress notes indicated no nursing progress notes were entered after 6/21/23. During an interview on 6/26/23 at 5:29 p.m., R11 stated she was supposed to get a shower that morning, but staff told her they didn't have time and therefore, she did not get one. During an interview on 6/29/23 at 1:31 p.m., nursing assistant (NA)-H stated because they were short staffed on 6/26/23, none of the resident showers or baths were done on the seventh floor that day. NA-H further stated the nurses "all knew" the NAs were unable to get any of the resident baths done. NA-H stated that was why she charted "Not Applicable" on R11's bath log in her EMR. During an interview on 6/28/23 at 1:14 p.m., the assistant director of nursing (ADON) stated NAs were to chart in the resident's electronic medical record (EMR) when they gave the resident a shower. If the staff were unable to give the resident a shower or bath, the NA was to notify the nurse who should enter a progress note. The ADON stated she was unaware any residents had not received showers or baths that week, although they did occasionally have staffing shortages. During an interview on 6/29/23 at 2:12 p.m., the director of nursing (DON) stated residents should receive a shower or bath at least weekly according to their bath schedule. If staff were unable to complete a resident's shower or bath, staff should have notified the nurse, and the	F 677		

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F 677	Continued From page 21 nurse should have entered a progress note in the resident's EMR so the nurse manager was aware the resident didn't get a shower. The DON verified there was no progress note indicating R11 did not get her scheduled, weekly shower on 6/26/23.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 3 of 3 residents (R10, R59 and R 135) reviewed for activities. Findings include: R10 R10's Admission Record dated 6/28/23, indicated R10's original admission date was 11/1/2004 with diagnoses of dysphagia (difficulty swallowing) following cerebral infarction, aphasia (a language disorder that affects a person's ability to communicate), hemiplegia (paralysis of one side of the body), and hemiparesis (weakness or the inability to move one side of the body) following	F 679	R10, R59, R135 are being offered and assisted to participate in activities weekly to support their physical, mental, and psychosocial well-being. Their assessments will be completed. Residents will be re-offered and assisted to participate in activities weekly to support their physical, mental, and psychosocial well-being Therapeutic Recreation staff have been educated to ensure providing for TR activities for dependent residents. Director of TR/Designee will be	9/1/23

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LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 679	Continued From page 22 cerebral infarction affecting left non-dominant side. R10's quarterly Minimum Data Set (MDS) dated 3/13/23, indicated R10 had severe cognitive impairment, received enteral feeding via gastric tube, and was totally dependent on staff with all activities of daily living. During documentation review R10's Activity Interview for Daily and Activity Preferences, was last completed on 10/4/21. R10's Therapeutic Rec/Life Enrichment Assessment was last done on 6/20/22. Additionally, R10's undated care plan, indicated "the resident has little or no activity involvement due to physical limitation of hemiplegia and hemiparesis. As well as due to language barrier and vascular dementia." Care plan goal indicated R10 will passively participate in activities of choice 2-4 times per week. R10's care plan interventions, included to invite and encourage family to attend activities with resident, resident needs assistance/escort to activity functions, resident's music, and TV channel preferences. Interventions also indicated, R10 preferred to listen to music, attending worship, dog visits, outside visits and visits from family. During observation on 6/26/23 at 1:36 p.m., R10 was observed in bed, awake, blinds closed. During interview n 6/26/23 at 6:07 p.m., family member (FM)-B stated the staff never get R10 up on her wheelchair, unless it is requested by a visiting family member. On 6/27/23 at 8:18 a.m., R10 was sleeping in bed. At 10:00 a.m. R10 was awake in her bed, the blinds in her room were closed, no TV or	F 679	responsible for ensuring compliance by checking 5 random participation records with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 679	Continued From page 23 music were playing in her room. R10 remained in her room, in bed throughout the morning and the afternoon. During observation on 6/28/23 at 7:18 a.m. R10 was sleeping in bed and at 11:30 a.m. R10 was awake in bed with the blinds closed. During interview on 6/28/23 at 1:03 p.m., recreational therapist (RT)-A confirmed R10's annual assessment for activities was last done on 10/4/21 and the quarterly assessment for activities was last done on 6/20/22. (RT)-A also confirmed, R10 had not attended any activities in the month of June 2023. R59 R59's Admission Record, dated 6/28/23, indicated R59 was admitted to the facility on 8/3/19, with diagnoses of quadriplegia (paralysis of all four limbs), disease of spinal cord, dysphagia, adjustment disorder with mixed anxiety and depressed mood. R59's quarterly Minimum Data Set (MDS) dated 5/19/23, indicated R59 was cognitively intact, received enteral nutrition and was totally dependent on staff members for activities of daily living. R59's Activity Interview for Daily and Activity Preferences, was last completed on 8/26/21. R10's assessment titled Therapeutic Rec/Life Enrichment Assessment was last done on 10/12/22. R59's activities care plan dated 8/13/19, indicated R59 was dependent on staff for meeting emotional, intellectual, physical, and social needs	F 679		

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F 679	Continued From page 24 related to physical limitations. R59's care plan goal indicated, the resident will maintain involvement in cognitive stimulation, social activities as desired through review date. A review of R59's care plan intervention, indicated "resident's preferred activities are socializing in dining room and with family when they visit, watching the news, and listening to music or book on tape." R59's care plan also indicated, the resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events. During interview on 6/26/23 at 5:20 p.m., R59 indicated she would like to get up and get out of her room, but staff won't help her. During interview on 6/28/23 at 7:30 am, R59 stated during the last several weeks she had not participated in any activities, either in her room or outside her room. During interview on 6/28/23 at 1:03 p.m. the recreational therapist (RT)-A confirmed R59's annual assessment for activities was last done on 8/26/21 and the quarterly assessment for activities was last done on 10/12/22. (RT)-A also confirmed, R10 had not attended any activities in the month of June 2023. (RT)-A stated he these assessments were required either quarterly or with significant changes and/or annually but they were not done in this instance. R135 R135's Clinical Resident Profile printed on 6/29/23, indicated R135 was admitted on 12/10/20, with diagnoses of hemiplegia and hemiparesis following cerebral infarction. R135's quarterly Minimum Data Set (MDS) dated	F 679		

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F 679	Continued From page 25 4/19/23, indicated resident had severe cognitive impairment, received enteral feeding, and needed assistance with all activities of daily living. R135's Activity Interview for Daily and Activity Preferences, completed with annual and significant changes was last completed on 10/20/21. R10's assessment titled Therapeutic Rec/Life Enrichment Assessment completed with quarterly MDS assessments was last done on 4/2/22. R135's activities care plan revised on 5/11/22, indicated "the resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive impairment and aphasia following stroke." Care plan interventions indicated R135 needed 1:1 bedside/in-room visits and activities if unable to attend out of room events. Interventions also indicated, R135 preferred activities were watching TV, looking at magazines, playing cards, visits from family and dog visits. During observations on 6/26/23 at 6:34 p.m., 6/27/23 at 10:31 a.m., and 6/28/23 at 10:28 a.m. R135 was in bed with the television on. During interview on 6/28/23 at 10:12 a.m., licensed practical nurse (LPN)-D stated R135 only gets out of bed to be weighed and requests to get back to bed as soon as possible. (LPN)-D stated R135 did not participate in any recreational activities. During interview on 6/28/23 at 1:03 p.m. the recreational therapist (RT)-A stated he visited with R135 but didn't document those visits. (RT)-A confirmed R135's annual assessment for	F 679		

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F 679	Continued From page 26 activities was last done on 10/20/21 and the quarterly assessment for activities was last done on 4/2/22. Facility policy titled Therapeutic Recreation revised 3/20/13, indicated "Residents of Walker Methodist facilities will have the opportunity to participate in meaningful and enjoyable leisure pursuits with as little disruption as possible. Residents have the right to participate in leisure pursuits that are consistent with their normal routines and lifetime preferences. This includes, but is not limited to social, religious and community activities that do not interfere with the rights of other residents in the facility. Walker Methodist will to the extent possible, accommodate an individual's needs and choices for how he/she spends time."	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 686	R92 will have toileting and offloading care	9/1/23

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F 686	Continued From page 27 review, the facility failed to timely turn and reposition, and adjust wound treatment and follow physicians orders for a wound consult for 1 of 1 resident (R92) who had a facility acquired Stage II pressure injury (opening in skin caused by pressure that is not in the tissues). R92's significant change Minimum Data Set (MDS), dated 4/18/23, indicted R92 was cognitively intact and required extensive assistance with transfers, bed mobility, dressing, toileting, and personal hygiene. The MDS further indicated R92 was at risk for pressure injuries. R92's Medical Diagnosis list indicated R92 had a primary medical diagnosis of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood). R92'S care plan, dated 4/25/23, indicated R92 previously had a Stage II pressure injury to her right buttocks. Interventions included following facility protocols for the prevention of skin breakdown and encouraging R92 to change positions or offload weight. R92's Wound Assessment, dated 4/7/23, indicated R92 had moisture associated skin damage (MASD) measuring 4 centimeters (cm) x 2.5 cm. R92's progress note, dated 4/25/23, indicated R92 had a "stage II pressure injury to buttocks". R92's physician visit note, dated 5/1/23, indicated R92 had a "gluteal (buttocks) pressure injury noted on exam today - wound care team to assess".	F 686	plans reviewed for appropriateness. Like residents will be reviewed. Nursing staff will be re-educated on following skin integrity/ interventions, toileting and repositioning quarterly x 2. Physician orders will be entered in PCC within 8 hours of obtaining wound orders. Director of Nursing/Designee will be responsible for ensuring compliance by checking repositioning for 5 random residents with Weekly audits x 4 and Monthly x 2. Director of Nursing/Designee will be responsible for ensuring compliance with physician wound orders by conducting 5 random audits Weekly x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 686	Continued From page 28 R92's physician orders, dated 5/4/23, indicated R92 had an order for "wound care team to assess". R92's entire electronic medical record (EMR) lacked evidence the order for "wound care team to assess" was followed up on. The EMR further lacked any evidence of wound care being done for R92's pressure injury to her gluteal area or other interventions to prevent skin breakdown. During an interview 6/27/23 at 9:09 a.m., R92 stated she had a sore on her buttocks that was "itchy and painful". R92 stated it got worse the longer she sat in a wet brief during the day, stating some days she only gets her brief changed in the morning. During observation and interview on 6/28/23 at 9:25 a.m., licensed practical nurse (LPN)-F and nursing assistant (NA)-F were providing incontinent care to R92. NA-F had notified LPN-F of an open area on R92's buttocks. LPN-F stated it appeared to be a pressure injury from "moisture and pressure" LPN-F measured the open are on R92's buttocks as 5.5 cm x 2.5 cm. LPN-F brought in a new tube of barrier cream to apply to R92's buttocks per facility protocol. NA-F stated R92 needed assistance from one staff member to transfer and was dependent on staff for toileting/incontinent care. NA-F placed a sheet over R92's wheelchair seat, stating that R92's incontinent brief often leaks urine throughout the day and the sheet protects the wheelchair seat. At approximately 9:30 a.m., NA-F transferred R92 to her wheelchair. LPN-F and NA-F both confirmed there were no current interventions or orders for wound care or skin breakdown prevention.	F 686		

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F 686	Continued From page 29 During observation on 6/28/23 at 11:46 a.m., R92 was still up in her wheelchair, watching television. No staff assistance with repositioning, offloading weight or changing R92's brief. During observation on 6/28/23 from 12:00 p.m., to 12:50 p.m., R92 was out eating lunch and then went outside to smoke without staff interaction to encourage offloading weight or offer a brief change. During observation on 6/28/23 at 1:30 p.m., R92 was still up in her wheelchair without staff offering to change R92's brief or encouraging offloading weight since 9:30 a.m. During an interview on 6/29/23 at 12:55 p.m., the director of nursing (DON) stated the expectation for residents at risk for, and with existing, pressure injuries was to have orders for wound care or to use standing orders if necessary. The DON stated she would expect staff to do rounds every 2 hours to check/change the resident's brief and reposition or offload weight. The DON reviewed R92's chart and further confirmed there were no wound care orders or interventions and the order for wound care team to assess from 5/1/23 was not followed up on. A facility policy titled Standing Orders for Long Term Care Facilities, revised 4/2022, indicated standing orders for skin and wound management with interventions to use moisture barrier cream to keep irritants or moisture from skin and stage II Pressure injury wound care. A facility policy titled Skin and Wound Care Patient Care Services, revised 8/1/19, indicated	F 686		

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F 686	Continued From page 30 residents will be assessed for their risk for developing pressure injuries to ensure a resident who is admitted without a pressure injury does not develop a pressure injury unless clinically unavoidable and that a resident who has a pressure injury receives care and services to promote healing and prevent additional skin breakdown.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a resident with a limited range of motion with a care planned nursing restorative program and splints for 2 of 2 resident (R49 and R141) reviewed for range of motion.	F 688	R141 has had restorative program reviewed and care plan revised to meet current needs. Residents on ROM programs will be reviewed for appropriateness.	9/1/23

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F 688	Continued From page 31 Findings include: R141's quarterly Minimum Data Set (MDS), dated 5/10/23, indicated R141 needed extensive assistance with all activities of daily living with short-term and long-term memory problems. R141'S Medical Diagnoses list indicated R141 had a primary diagnosis of hemiplegia (one-sided muscle paralysis) and hemiparesis (weakness on one side of the body) following a non-traumatic intracranial hemorrhage affecting the right side (bleeding into the substance of the brain in the absence of trauma or surgery). R141's care plan, dated 6/24/22, indicated R141 was on a nursing maintenance program indicating, "do these exercises 1xday for right arm: Move shoulder up, down. Move elbow in, out. Rotate forearm up, down. Bend wrist up, down. x10 each movement. Move slowly, within patient's tolerance and without pain." The electronic medical record (EMR) indicated this had been done once, on 6/4/23 in the past 30 days. R141's care plan, dated 5/18/23, indicated R141 had a palm guard contracture splint to be worn on right hand at all times and instructions included, "Use rolled washcloth if she declines splint." R141's progress notes lacked any documentation of R141 refusing cares or splints. During observation on 6/26/23 at 6:48 p.m., R141 was in bed without any splints on. R141's right hand was contracted into a fist. During an observation on 6/27/23 at 11:00 a.m.,	F 688	Nursing staff and rehabilitation staff will be re-educated on restorative programs. Director of Nursing/Designee will be responsible for ensuring compliance by checking ROM and application of assistive device is being documented correctly for 5 random residents with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 688	Continued From page 32 R141 was in bed without any splints on. R141's right hand was contracted into a fist. During observation on 6/28/23 at 7:18 a.m., R141 was out at the breakfast table without any splints on. During an interview on 6/28/23 at 10:00 a.m., nursing assistant (NA)-G stated R141 does not get any splints or stretching program stating, "I wish she did". NA-G further stated the NA's use the care plan and Kardex to know what cares to provide the residents. During an interview on 6/28/23 at 1:30 p.m., the director of rehab (DOR) stated R141 was admitted after she had a "massive stroke". The DOR further stated without her participating in her nursing rehab program she, "wouldn't be surprised if she had gotten a little tighter" since being admitted to the facility on 5/6/20. During an interview on 6/29/23 at 8:38 a.m., registered nurse (RN)-E stated R141 can communicate well with yes or no questions. RN-E stated she was unaware of any nursing restorative program or splints for R141. During an interview on 6/29/23 at 8:52 a.m., trained medication assistant (TMA)-A stated he was unaware of any restorative program or splints for R141. TMA-A further stated he was aware of R141 being on a range of motion program in the past but was unaware of any current programs. During an interview on 6/29/23 on 8:55 a.m., registered nurse (RN)-H stated she would expect the care plan to be followed at all times and	F 688		

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F 688	Continued From page 33 confirmed R141's care plan had range of motion exercises to R141's right side. During an interview on 6/29/23 at 12:55 p.m., the director of nursing (DON) indicated the nursing restorative programs were developed by therapy and completed by the NAs and nurses based off of what is on the care plan. The DON further stated there would be concerns of not keeping residents at their baseline or the resident declining if nursing restorative programs were not being completed. A facility policy titled Restorative Nursing Program, revised on 5/12/19, indicated the facility, "can provide a restorative nursing program to assist residents to achieve and/or maintain an optimal level of function". The policy indicated a restorative nursing program involved activities aimed at improving functional abilities including range of motion and splint/brace assistance.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from potential hazards to ensure their safety	F 689	R11 has had faulty power strip removed from her room.	9/1/23

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	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 689	Continued From page 34 for 1 of 1 resident (R11) who was found by facility staff to have a smoking and a sparking electrical power strip in her room. The power strip was not removed after the incident and was still in use at the time of the survey and discovered to have black soot marks on 1 outlet on that power strip. 2 other power strips were observed in the boiler room and fitness room by the Fire Marshall and has the potential to affect all other residents in R11's wing, those residents and staff located near the boiler room, and who used the fitness room. In addition, the facility failed to ensure the safety of 1 of 1 resident (R92) who failed to discard cigarettes in a safe manner inside the building, had a history smoking in unauthorized places, and had a history of burnt clothing as a result of unsafe smoking. Refer also to K741 and K920 for additional information. Findings include: R11's quarterly Minimum Data Set (MDS) dated 3/23/23, indicated R11 had intact cognition,and extensive assistance for all other activities of daily living (ADLs). R11's diagnoses included major depression, bipolar disorder (a mental health condition that causes extreme mood swings), anxiety, history of suicidal ideation, presence of a neurostimulator (an implanted stimulator to control pain), overactive bladder, cataracts, and hoarding disorder. R11's Care Area Assessment (CAA) dated 6/24/22, indicated R11 triggered for visual function, communication, and an indwelling catheter.	F 689	R92 Smoking assessment has been reviewed and revised. Residents rooms will be checked for appropriate power strip usage. Residents that smoke and require a smoking apron will be checked to ensure that they are using smoking aprons appropriately. Maintenance staff have been re-educated on the approved use of power strips within the facility and instructed to remove any they observe and follow-up with maintenance department. Social service will be re-educated on Facility smoking policy to ensure residents re safe and appropriate interventions are in place. Maintenance Director/Designee will be responsible for ensuring compliance by checking 5 random rooms for power strips with Weekly audits x 4 and Monthly x 2. Social Services Director/Designee will be responsible for ensuring compliance by checking 5 smoking assessments randomly with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 689	Continued From page 35 R11's care plan, undated, indicated R11 had a potential for abuse with interventions that included providing a safe environment. R11 had a behavioral issue related to hoarding, bipolar disorder and anxiety. Interventions included staff assessing R11's room weekly for cleaning and reminding and encouraging R11 to keep her room free of clutter. R11 also had bowel incontinence and staff were to check R11 every two hours. R11's care plan lacked indication of having a power strip in her room or that it had malfunctioned. R11's progress note dated 6/10/23, indicated R11 was heard "calling for help." Upon arrival to R11's room, there was an odor of smoke, and the staff could hear sparks and "knew that something was burning in her [R11's] room." Staff identified the cause to be earbuds plugged into a round power strip on the floor next to R11's bed. The staff unplugged the earbud charger and the "sparkling stopped." Maintenance was then notified because the "room still smelled of smoke." No further progress notes regarding the incident were made. During an interview and observation on 6/26/23 at 5:23 p.m., R11 was in bed. A round, eight-outlet power strip was on the floor next to R11's bed with a rectangular, cardboard, 24-soda can box, containing five unopened cans, balanced on top of the plugged-in charging cords. R11 stated she had a suprapubic urinary catheter that often leaked and would soak her bed linen. R11 stated a few weeks prior, urine had dripped off her linen into the power strip on the floor next to her bed and started a fire. R11 stated she yelled for help and after 30 min. Staff arrived and saw smoke	F 689		

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F 689	Continued From page 36 coming from a charger that was plugged into the power strip. The unknown staff member removed the smoking charger from the power strip, then called maintenance. R11 stated maintenance came to her room and told R11 her power strip was "overloaded" although R11 stated she only had four items plugged into the eight possible outlets. R11 stated her earbuds cord was no longer functional and therefore, no longer plugged into the power strip. R11 also stated the incident shorted the phone used to monitor her neurostimulator and the physician's office staff had to replace the charging cord during her last appointment. The power strip was covered in a dried, brown, dirt-like substance and 1 un-used outlet had black soot around it. Continued observation on 6/26/23 at 5:23 p.m., of the charging cords plugged into the power strip were as follows: 1) The cell phone that monitored the strength and status of the implanted neurostimulator device in R11's back to send information to offsite clinical staff, 2) R11's hearing aid charging container, 3) A radio, 4) R11's personal cell phone, 5) Headphones. During an interview on 6/28/23 at 9:42 a.m., the Fire Marshall (FM) observed R11's power strip and verified the black, soot around the outlet indicated there had been a fire in the power strip. The FM stated there was also concern because the power strip was in close proximity to R11's urinary catheter bag. The FM stated the power strip was not "medical grade" and should not have been used in R11's room or for charging medical devices (neurostimulator monitor or	F 689		

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F 689	Continued From page 37	F 689		

hearing aids). The FM further stated the power strip needed to be removed from operation immediately to avoid a subsequent electrical fire.

During an interview on 6/28/23 at 10:08 a.m., nursing assistant (NA)-I stated she was unaware of the smoke and possible fire from R11's power strip. NA-I also stated she had not been told residents were not allowed to have power strips.

During an interview on 6/28/23 at 10:10 a.m., NA-J stated he was unaware R11's power strip had been smoking and sparking but that "many residents" had used power strips. NA-J also stated he did not know if residents were allowed to have power strips but that they were considered a fall hazard.

During an interview on 6/28/23 at 1:11 p.m. the assistant director of nursing (ADON) stated it would have been the maintenance department's responsibility to follow up on the safety and continued use of R11's power strip after it had been found to be sparking and smoking, however, the assistant director of nursing (ADON) stated she would have expected the power strip to be removed after the incident on 6/10/23 but acknowledged they had not overseen staff to ensure that had occurred.

During an interview on 6/29/23 at 11:51 a.m., maintenance staff (M)-A stated on 6/10/23, he was notified that R11's power strip had been smoking. Upon entry to R11's room, M-A stated he smelled smoke, but staff had already removed the charging cord from R11's power strip that had been thought to be the cause. MT-A stated the power strip had "tripped" so he reset it. MT-A verified he saw black "burn" marks around the

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F 689	Continued From page 38 outlet where the (earbud) charging cord had been plugged in, but the power strip appeared to be working well, therefore, he left it in R11's room with the remainder of the charging cords plugged into it and did not notify the director of maintenance (DMT). During an interview on 6/28/23 at 12:22 p.m., the DMT stated the power strip in R11's room should not have been used and he did not believe it was one the facility supplied. The DMT also stated he was unaware of the power strip or the possible fire that occurred on 6/10/23 and would have expected to be notified by his maintenance staff and through a workorder from the facility staff. The DMT verified no workorder had been submitted for R11's power strip. During an interview on 6/29/23 at 2:05 p.m., the director of nursing (DON) stated power strips were only allowed to be used for electronic devices such as computers and printers. The DON stated she was unaware of the incident on 6/10/23, with R11's power strip and, although maintenance was responsible for the use and safety of power strips, the DON expected all staff to be aware of power strips being used inappropriately or malfunctioning and report concerns to the management staff. Review of the facility's Use of Power Strips policy dated 6/13/16, indicated power strips were allowed to be used for electronic equipment only (computers, monitors, and printers). Power strips were not to be used for any devices other than electronic equipment. A handwritten note further indicated "Power strips must meet 1363 UL rated or greater."	F 689		

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F 689	Continued From page 39 R92's significant change MDS, dated 4/18/23, indicted R92 was cognitively intact and required extensive assistance with transfers, bed mobility, dressing, toileting, and personal hygiene. R92's Medical Diagnosis list indicated R92 had a primary medical diagnosis of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood). R92's care plan, dated 10/19/21, indicated R92 required a smoking apron while out to smoke due to a history of falling asleep with cigarettes in her hand. During observation and interview on 6/27/23 at 9:13 a.m., R92 was sitting outside under the "No Smoking" sign, smoking a cigarette without a smoking apron on. R92 stated she would put out her cigarettes and throw them away in the garbage can in the vestibule of the facility (inside the facility). The plastic lined garbage can had several cigarette butts in it. R92 further stated she often falls asleep in her power chair and needed to use the seatbelt to prevent herself from falling out. During observation on 6/27/23 at 10:45 a.m., R92 was observed asleep outside in her power chair with two cigarette butts in her hands and without a smoking apron on. During observation on 6/28/23 at 10:35 a.m., R92 was observed outside, smoking under the "No Smoking" sign without a smoking apron on. During an interview on 6/28/23 at 11:58 a.m.,	F 689		

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F 689	Continued From page 40 registered nurse (RN)-F confirmed it was care planned for R92 to wear a smoking apron for safety because she falls asleep while smoking. During an interview on 6/29/23 at 12:55 p.m., the DON stated she would expect that staff follow the resident care plans at all times. A facility policy titled Smoking Guidelines - Skilled Administration, revised 6/2022 indicated, "residents that smoke, individualized goals, and approaches will be documented in the resident plan of care and communicated to direct care staff". The policy further indicated the facility complies with the "Minnesota Clean Indoor Air Act and each community will determine if and where residents smoke".	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		9/1/23

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F 693	Continued From page 41 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a feeding tube and feeding tube supplies were labeled according to professional standards to avoid the possibility of feeding tube complications and or related infections for 3 of 3 residents (R10, R59 and R135). Findings include: R10's Admission Record dated 6/28/23, indicated R10's original admission date was 11/1/2004. Diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (tissue damage related to lack of blood supply to the brain), aphasia (a language disorder that affects a person's ability to communicate), hemiplegia (paralysis of one side of the body), and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting left non-dominant side. R10's quarterly Minimum Data Set (MDS) dated 3/13/23, indicated R10 had severe cognitive impairment, received enteral feeding via a gastric (stomach) tube, and was totally dependent on staff for all activities of daily living. R10's Order Summary Report indicated "Enteral Feed order two times a day, Glucerna 1.5 at 45 ml/hr [milliliters per hour] for 22 hours daily. Stop tube feeding from 3:30 p.m.-5:30 pm. Monitor for s/sx [sign/symptoms of] intolerance." The Order	F 693	R10, R59, R135 have tube feeding solution bottles and irrigation supplies dated and changed out per policy. R10 & R59 have had tube feeding pumps and poles cleaned of dried tube feeding solution. Residents receiving enteral feeding will be checked to ensure that they are being dated and changed appropriately. Residents with feeding pumps and poles will be cleaned of dried tube feeding solution. Licensed nursing staff have been educated on the expectations to change out and date tube feeding solution & supplies per policy and to clean/change out pumps/poles when soiled. Director of Nursing/Designee will be responsible for ensuring compliance by checking 5 random tube feeds and poles with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 693	Continued From page 42 Summary Report also directed staff to flush the gastric tube with 30 milliliters (ml) of water before and after each medication administration, and to flush the gastric tube with 275 ml of water every four hours for hydration. R10's Care Plan revised 9/28/22, indicated R10's required gastric tube feeding related to dysphagia due to a cerebral infarction. R10's care plan goal indicated, R10 will remain free of side effects or complications related to tube feeding. During observation on 6/26/23 at 1:36 p.m., R10 was receiving enteral nutrition at 45 ml/h. A bottle of Glucerna 1.5 hung from a feeding pole and the label was blank. The label included "patient, room, date, start time AM/PM, rate ml/hr." Additionally, observed was a 60 ml irrigation syringe inside an undated irrigation bottle partially filled with water. During further observations on 6/26/23 at 4:49 p.m., 6/27/23 at 8:40 a.m., and 6/28/23 at 8:09 a.m. demonstrated lack of information on R10's enteral feeding bottle. During observation on 6/28/23 at 8:17 a.m., R10's feeding pump was beeping, and the screen displayed a "feed error" alert. The feeding pump and the pump's pole had several ochre yellow-colored spots of dry matter. During interview on 6/28/23 at 8:19 a.m. conducted in R10's room, nurse manager (RN)-D stated the nurses are expected to fill and date the tube feeding bottle's label and date the irrigation bottle used to contain the irrigation syringe. During interview on 6/28/23 at 1:53 p.m. the	F 693		

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F 693	Continued From page 43 director of nursing (DON) stated the nurses are expected to label and date the tube feeding formula bottles and date the irrigation bottles used to contain the syringes. R59 R59's Admission Record dated 6/28/23, indicated R59 was admitted to the facility on 8/3/19, and included diagnoses of quadriplegia (paralysis of all four limbs), disease of spinal cord, dysphagia, adjustment disorder with mixed anxiety and depressed mood. R59's quarterly Minimum Data Set (MDS) dated 5/19/23, indicated R59 was cognitively intact, received enteral nutrition and was totally dependent on staff members for activities of daily living. R59's Order Summary Report indicated, "Enteral feeding Order, provide Jevity 1.5 75 ml/h for 12 hours. On at 2100, off at 0900 daily. Monitor for signs and symptoms of tolerance." Orders also indicated to administer 60 ml of water flushes every 6 hours and to flush tube feeding with 30 ml of water "before and after tube feed". R59's Enteral care plan revised on 5/20/22 indicated, R59 required tube feeding related to muscle weakness, contractures, dysphasia, history of malnutrition and anemia. R59's care plan indicated "the resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders." R59's Treatment Administration Record for June 2023, directed staff to change the irrigation syringe every day on night shift.	F 693		

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F 693	Continued From page 44 During observation on 6/26/23 at 12:50 p.m., R59 was in bed. On the left side of the bed was a tube feeding pole with a feeding pump and 1/3 full bottle of Jevity 1.5. On the nightstand, there was an irrigation syringe inside a bottle dated 6/22/23. The label of the Jevity 1.5 bottle included "patient, room, date, start time AM/PM, rate ml/hr". The tube feeding pump and the pole were dirty with several ochre yellow spots of dry matter, and the pole's base was dusty. During observation on 6/27/23 at 8:10 a.m., R59's Jevity bottle's label was blank and the bottle used to contain the syringe was dated 6/22/23. During interview on 6/28/23 at 8:19 a.m., the (RN)-E stated the nurses are expected to date the tube feeding bottles and the irrigation bottle used to contain the irrigation syringe. During interview on 6/28/23 at 1:53 p.m., DON stated the tube feeding bottles and the irrigation bottles needed to be dated per standards of practice and follow the physicians orders regarding how often to change the irrigation syringe. R135 R135's Clinical Resident Profile printed on 6/29/23 indicated, R135 was admitted on 12/10/20, and diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction right dominant side. R135's quarterly Minimum Data Set (MDS) dated	F 693		

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F 693	Continued From page 45 4/19/23, indicated R135 had severe cognitive impairment, received enteral feeding, and needed assistance with all activities of daily living. R135's Order Summary Report dated 7/3/23 indicated, "enteral feed Glucerna 1.5 at 75 ml/hr at 1800 for 16 hours and stop at 1000 daily via PEG. Monitor for s/s of intolerance and notify RD [registered dietician] with any concerns". Enteral orders also directed staff to provide fluid flushes of 250 ml every 3 hours, and to change syringe daily every night shift. During observation on 6/26/23 at 6:34 p.m. R135 was in bed and there was a tube feeding pole with a pump. The pump was off and there was no formula hung on the pole. On the nightstand there was an irrigation bottle partially filled with water containing an irrigation syringe. The bottle was not dated. During interview on 6/28/23 at 8:19 a.m., (RN)-D stated it was expected the tube feeding bottles will be dated, and include the patient's name, time, infusion rate and nurse's name/initials. (RN)-D verified the tube feeding pole and the pump were soiled. During interview on 6/28/23 at 1:53 p.m., DON stated the tube feeding bottles and the irrigation bottles needed to be dated per standards of practice. The policy titled Enteral Tube Feeding via Gastrostomy/Jejunostomy revised on 7/22/16 indicated, "Gastrostomy/Jejunostomy feeding solution shall be administered through an enteral tube per a physician's or nurse practitioner's orders by a license nurse. Resident privacy,	F 693		

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	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 693	Continued From page 46 infection control and documentation standards will be maintained per Walker Methodist policies and procedures."	F 693		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement immediate interventions for 1 of 1 resident with repeated suicidal ideation and depression, provide 1:1 supervision until it was determined she was no longer a threat to herself, and perform an immediate safety check of the resident and her surroundings to ensure her safety and mental well-being. Findings include: R137's quarterly Minimum Data Set (MDS), dated 5/31/23, indicated R137 had moderate cognitive impairment and needed supervision with all activities of daily (ADLs). R137's Medical Diagnosis List indicated R137 had several medical diagnoses including major	F 740	R137 trauma care plan will be reviewed and be followed up on as appropriate. Appropriate interventions for suicidal ideations are in place. Residents with suicidal ideations within the last 60 days will be assessed for interventions. Residents with trauma care plans will be reviewed for appropriateness. Social Service and licensed nursing staff will be re-educated on the appropriate follow-up and documentation for suicidal residents. Social Service will be re-educated on	9/1/23

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F 740	Continued From page 47 depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and adjustment disorder with mixed disturbance of emotions and conduct (symptoms include behavioral issues such as acting rebellious, destructive, reckless or impulsive), dated 5/26/22, and personality disorder (a deeply ingrained pattern of behavior of a specified kind that deviates markedly from the norms of generally accepted behavior and causing long-term difficulties in personal relationships or in functioning in society), unspecified dementia and toxic encephalopathy (brain dysfunction caused by toxic exposure), dated 10/21/21. R137's care plan indicated R137 displayed social, emotional, and psychological symptoms resulting from actual trauma with no updated interventions since 12/6/22. R137's care plan further indicated R137 at times isolated herself in her room due to delusions about another resident staring at her and was at risk for self-injury as evidenced by reporting she wants to jump out the window. Interventions last updated on 12/12/22. R137's progress notes indicated R137 had at least 6 documented episodes of self-isolation or making suicidal comments. On: 1) 4/14/23 at 1:31 p.m., it was documented R137 reported that residents were looking at her and she "didn't like it". 2) 4/29/23 at 1:45 p.m., it was documented R137 had increased anxiety and presented with signs of harming herself, stating she was going to end her life using a butter knife or jumping out the window. It was documented, "the interventions seem to not help."	F 740	trauma care plans Social Services. Director/Designee will be responsible for ensuring compliance by checking 5 trauma care plans randomly and 2 residents with suicidal ideations randomly through Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 740	Continued From page 48 3) 4/29/23 at 10:00 p.m., it was documented R137 stated that a lady that lived at the facility was always staring at her, making her feel like staying in her room. R137 verbalized "I can't go on like this." 4) 4/30/23 at 11:25 p.m., it was documented R137 was crying, stating she felt like "jumping out the window" and "I just can't take it here anymore, nobody likes me." 5) 5/4/23 at 10:17 a.m., it was documented R137 was agitated, stating she did not like the way other residents were looking at her. 6) 6/13/23 at 11:07 a.m., it was documented that social work followed up with R137 due to continued suicidal statements. There was no indication staff had taken immediate steps to protect R137's safety by providing 1: 1 supervision and checking her person and environment for object or chances to fulfill her statements of suicidal ideation. During observation and interview on 6/26/23 at 4:30 p.m., R137 was in her room, yelling she was "trapped in her room all day" because of a resident who stared at her. R137 stated she was going to "leave or jump out of a window." During an interview and observation on 6/27/23 at 8:36 a.m., R137 was in her room and stated she doesn't like to leave her room because of a resident who stares at her. During an interview on 6/28/23 at 9:55 a.m., R137 was upset about a resident staring at her, stating "It's not fair, I shouldn't have to stay in my room all day because of this resident." During an interview on 6/29/23 at 9:00 am., R137 stated she was "ready to throw that woman (the	F 740		

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F 740	Continued From page 49 resident who stares at her) on the floor." R137 further stated, "It's not fair I have to stay in my room. I have let a lot of people (staff at the facility) know but I am ready to just kill myself." During observation on 6/29/23 at 9:23 a.m., R137 was in her room, alone. During an interview on 6/29/23 at 8:43 a.m., licensed practical nurse (LPN)-F confirmed R137 frequently makes comments about being frustrated with a resident who stares at her when she is out of her room. During an interview on 6/29/23 at 8:55 a.m., registered nurse (RN)-H confirmed it had been reported to her R137 frequently made statements abut wanting to hurt herself. RN-H agreed staff should have taken steps to provide 1:1 supervision and perform a threat assessment to ensure her safety. During an interview on 6/29/23 at 11:00 a.m., the director of social services (DSS) stated she was aware R137 made statements such as, "I can't take it anymore" and "I am going to jump out the window". The DSS stated she put interventions in the care plan back in December and conducted a suicide risk assessment when suicidal statements were made. The DSS stated "nothing new is learned" which is why the care plan had not been updated since December despite evidence of the interventions not being effective to manage R137's paranoia, suicidal statements, and self-isolation. The DSS further stated she would have expected staff to update her on R137's behavior and negative statements on 6/26/23 when they were made but had not been notified.	F 740		

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F 740	Continued From page 50 During an interview on 6/29/23 at 12:55 p.m., the director of nursing (DON) stated behavioral health services were typically managed by social services but nursing was also involved. The DON stated she would expect to see changes on the care plan if interventions were not effective or if a resident's behaviors were persistent and not improving. The DON was unaware if staff provided any 1:1 supervision immediately after her threats of self harm or performed a safety assessment on her person and environment to ensure her threats would not be carried out. A facility policy titled Behavioral Health Services, revised on 3/7/23, indicated the facility was to provide to residents the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and individual care plan. Behavioral health encompasses a resident's whole emotional and mental well-being. There was no indication the facility had any protocols in place immediately after threats of resident self harm or had a suicide prevention plan.	F 740		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		9/1/23

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F 758	Continued From page 51 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, document review and review	F 758	R190 psychotropic medication has been	

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F 758	Continued From page 52 of the Food and Drug Administration (FDA) warnings (www.fda.gov), the facility failed to ensure one resident (R-190) of five residents reviewed for unnecessary medications had adequate indications for the continued use of two different antipsychotic (Seroquel and Zyprexa) medications. In addition, the facility failed to ensure action was taken in response to possible adverse drug reactions when the resident had an increase in symptoms of abnormal involuntary movements (AIMS) related to taking antipsychotics. Findings include: Review of FDA guidelines titled "Highlights of Prescribing Information," dated 1996 and referring to the use of Zyprexa, revealed, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Zyprexa is not approved for the treatment of patients with dementia-related psychosis." Review of FDA guidelines titled "Highlights of Prescribing Information," dated 1997 and referring to the use of Seroquel, revealed, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for elderly patients with dementia-related psychosis." Review of a policy provided by the facility titled "Psychotropic Medications," dated 10/20/17, revealed that, "Patients/Residents shall not be administered psychotropic medication unless the medication is necessary to treat a specific condition as diagnosed and documented in the	F 758	reviewed by primary provider with dose of Olanzapine discontinued on 6/29/23. R190 other psychotropic medications were reviewed and target behaviors are in place and nursing staff re-educated regarding documentation. R190 had change in AIMs assessment value communicated to primary provider for review. Residents on psychotropics will have Target Behavior monitoring reviewed and updated as appropriate. Last 30 days of Pharmacy recommendations for dose reductions were reviewed to ensure follow-up. AIMS completed over the past 30 days will be reviewed to ensure provider notified as appropriate. Licensed Nursing Staff and Social Service Staff have been re-educated on target behavior monitoring to justify use of psychotropic medications. Nurse managers have been educated on follow-up of dose reductions recommended by pharmacist. Licensed staff have been educated on AIMs assessments, identification of change, proper notification of provider and documentation. Director of Nursing/Designee will be	

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F 758	Continued From page 53 medical record. A psychotropic medication will be defined as any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders. Classifications of psychotropic medications referred to in this policy include antipsychotics ...Every effort is made to ensure that patients/residents who use psychotropic medications receive the intended benefit of the medications and to minimize the unwanted effects of the medications. . . Gradual dose reduction for psychotropic medication. . .When a patient/resident is admitted on an psychotropic medication or if one is initiated at the community (new start), gradual dose reduction must be attempted the first year during two separate quarters, with at least one month between attempts unless clinically contraindicated. . .After one year of use, unless otherwise clinically contraindicated." a. Lack of Indication for Use: Review of a document provided by the facility, titled "Admission Record," indicated R190 was admitted to the facility on 11/28/22 with a diagnosis of dyskinesia (uncontrolled, involuntary muscle movements. Causes of dyskinesia include antipsychotic medication side effects.). Review of a document provided by the facility referred to as the care plan for R190, dated 12/01/22 indicated the resident had diagnoses of dementia with psychosis and drug induced dyskinesia and was on an antipsychotic medication. Review of R190's "Clinical Physician Orders," located under the "Orders" tab in the electronic	F 758	responsible for ensuring compliance by reviewing 5 resident□s behavior monitoring to ensure it has been completed with Weekly audits x 4 and Monthly x 2. Five pharmacy recommendations on random residents will be reviewed for dose reductions monthly. Director of Nursing/Designee will be responsible for ensuring compliance by audits of 5 residents x 4 Weeks and Monthly x 2. This will ensure appropriate notification was completed. Facility QA&A Committee will review audit results.	

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F 758	Continued From page 54 medical record (EMR) and dated 12/13/22, indicated the resident was prescribed Seroquel (antipsychotic medication) 12.5 milligrams (mg) two times per day for dementia with psychosis. On this same date, the resident was also prescribed Zyprexa (a different antipsychotic) 2.5 mg to be administered at bedtime for dementia with psychosis. Review of R190's "Progress Notes," located under the "Prog [Progress] Note" tab in the EMR from 01/16/23 to 06/27/23 revealed no evidence the resident was a danger to self or others, yelled out constantly, or had other verbal or physical aggressions. Review R190's EMR titled "Nursing Home Acute," located under the "Misc (Miscellaneous)" tab dated 03/21/23 failed to contain evidence that the resident had any physical or verbal aggressive behaviors. Review of R190's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 03/30/23, indicated the resident was severely cognitively impaired, as evidenced by a "Brief Interview for Mental Status (BIMS)" score of six out of 15. The MDS assessment documented the resident had no verbal or physical behaviors. Review of R190's EMR titled "Nursing Home Acute," located under the "Misc" tab dated 04/05/23 revealed no evidence that the resident had any physical or verbal aggressive behaviors. Review of R190's EMR titled "Nursing Home Acute," located under the "Misc" tab dated 05/03/23 failed to contain evidence that the resident had any physical or verbal aggressive	F 758		

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F 758	Continued From page 55 behaviors. During an interview on 06/28/23 at 7:18 a.m., licensed practical nurse (LPN)-A stated R190 was not verbally or physically aggressive. LPN-A stated the resident participated in activities and the resident was "very sweet." During an interview on 06/28/23 at 8:38 a.m., nursing assistant (NA)-C stated R190 will scream out if she receives some care but that was due to her wanting to do things herself. NA-C stated the resident enjoyed activities, especially attending church services. During an interview on 06/29/23 at 12:37 p.m., former consultant pharmacist (CP)-F was asked about the indication for the use of these antipsychotics and she responded that she could not question what the physician wrote. b. Use of antipsychotics in the presence of possible adverse drug reactions: Review R190's "AIMS," test, dated 03/30/23 and located under the "Assmnts [Assessment]" tab in the EMR revealed the resident scored seven, which indicated the resident had detectable abnormal movements. Review R190's "AIMS" test, dated 06/21/23, located under the "Assmnts" tab, indicated the resident now scored 11, which meant there was a significant increase in abnormal movements. During an interview on 06/29/23 at 12:37 p.m., former (CP)-F stated she made a recommendation, dated 04/16/23, for a possible	F 758		

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F 758	Continued From page 56 reduction of one of the antipsychotics R190 was taking. Consultant Pharmacist F stated the AIMS score of seven on 03/30/23 did not mean anything alone but indicated the need to possibly to look at the situation deeper with the resident. Consultant Pharmacist F stated the AIMS score of 11 on 06/21/23 definitely meant the resident needs to be evaluated and indicated her abnormal involuntary movements have become worse. During an interview on 06/29/23 at 12:50 p.m., clinical manager (CM)-B stated the AIMS score increase from seven to 11 indicated a significant change in R190's condition and the physician should have been notified. Interview on 06/29/23 at 1:10 p.m., with licensed practical nurse (LPN)-C revealed the resident had an increase in tics, tongue thrusting and other movements. During an interview on 06/29/23 at 2:29 PM, nurse practitioner (NP)-H stated he was not aware of the increase in R190's involuntary movements/AIMS score and should have been notified. (Refer to F580.)	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing	F 804		9/1/23

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F 804	Continued From page 57 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve food that was palatable and at appropriate temperatures to four of 38 residents residing on the 6th and 7th floors (R18, R103, R121, and R123). Foods that were to be served hot were not served at temperatures that met residents' tastes preferences. Findings include: Review of R18's electronic medical record (EMR) revealed a quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 05/02/23, located under the "MDS" tab. The assessment recorded a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 for R18, which indicated the resident was cognitively intact. During an interview on 06/26/23 at 3:07 PM, R18 stated that she eats her meals in her room and the "food is cold." Review of R103's EMR revealed a significant change in status "MDS" with an "ARD" of 04/13/23, located under the "MDS" tab. The assessment recorded a "BIMS" score of 12 out of 15 for R103, which indicated the resident was moderately cognitively impaired. During an interview on 06/26/23 at 1:50 p.m., R103 stated he eats his meals in his room and that "Everything is cold." Review of R121's EMR revealed a quarterly "MDS" with an "ARD" of 05/13/23, located under the "MDS" tab. The assessment recorded a	F 804	R121 and R123 have been served meals that are at appropriate temperatures. Residents are at risk for alleged deficient practices. Dietary Director and kitchen staff will be re-educated on maintaining proper food temperatures. Nursing staff will be educated on keeping food in warmer until ready for delivery. Dietary Director/Designee will be responsible for ensuring compliance by checking temperature on 5 meal trays randomly with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 804	Continued From page 58 "BIMS" score of 14 out of 15 for R121, which indicated the resident was cognitively intact. During an interview on 06/26/23 at 6:35 p.m., R121 stated she eats her meals in her room and that the "food is always cold, even breakfast." Review of R123's EMR revealed a quarterly "MDS" with an "ARD" of 04/29/23, located under the "MDS" tab. The assessment recorded a "BIMS" score of "99," indicating the assessment was not completed. During an interview on 06/26/23 at 1:05 p.m., R123 stated he ate his meals in his room and that he generally was served "cold food," that was "barely warm." In response to resident complaints about food, a test tray was requested on 06/28/23. Observation of temperatures of the food on the steam table on 06/28/23 at 11:30 AM, prior to serving and delivery of the test tray revealed that all foods were maintained at appropriate temperatures. They included: pureed mixed vegetables, 200.0 degrees Fahrenheit; mixed vegetables, 202.7 degrees Fahrenheit; cubed sweet potatoes, 158.0 degrees Fahrenheit; gravy, 165.0 degrees Fahrenheit; pork loin, 175.0 degrees Fahrenheit; and pureed pork loin, 206.0 degrees Fahrenheit. Interview with culinary manager (CM)-A revealed the lunch meal was to be served from 12:00 - 1:00 PM. CM A added that room trays were delivered after the meals were served to the residents eating in the dining room. The test tray was requested to be sent to the facility's 6th floor, which contained the last room trays to be served for the 2nd, 3rd, 5th, 6th, and 7th floors.	F 804		

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F 804	Continued From page 59 Observation revealed the trays were transported from the kitchen, which was located on the first floor, in an insulated food cart. The cart with the test tray left the kitchen at 12:45 PM and went up the elevator to the sixth floor. As trays were being served, the doors to the insulated cart were routinely left open. At 1:00 PM, after all room trays had been delivered, the test tray temperatures were taken and read: pork loin, 134.8 degrees Fahrenheit; cubed sweet potatoes, 108.0 degrees Fahrenheit; and mixed vegetables, 112.0 degrees Fahrenheit. At this time, the food on the test tray was sampled in the presence of the CM A. Tasting of the food revealed the following: a. The pork loin served on the test tray was warm when tasted. CM-A also tasted the pork loin and stated that the pork was "OK." b. The cubed sweet potatoes served on the test tray were not warm when tasted. CM-A said the potatoes were "cold and hard." c. The mixed vegetables served on the test tray were barely warm when tasted. CM-A confirmed that the mixed vegetables were "headed toward not warm." During an interview on 06/28/23 at 1:15 p.m., CM-A said the residents should be served hot food. CM A said the room trays needed to be delivered to the residents more quickly upon delivery to the floors. During an interview on 6/27/23 at 8:36 a.m., a resident's family member (FM)-A who was accompanying their resident in the dining room, approached, and stated the dining room meal	F 804		

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F 804	Continued From page 60 trays were delivered around 8:00 a.m., each morning, however, they often sat for an hour prior to being delivered. FM-A stated the previous day, by the time the dining room tray was delivered to his family member, the eggs were cold. During an observation and interview on 6/27/23 at 9:13 a.m., on the seventh floor, the final room tray was being delivered after being brought up for breakfast service at approximately 8:00 a.m. The culinary manager (CM) temped the egg substitute at 99 degrees Fahrenheit (F). The CM stated the eggs should have been at least 140 degrees F for palatability. Although requested, no policies were provided in regard to meal delivery service prior to exit from survey.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that food preferences were honored for one resident (R-21) of 35 sampled residents. The resident's request and physician orders for a vegetarian diet were	F 806	R21 is receiving vegetarian meals as preferred. R198 is being served her tray timely. Resident food preferences and tray cards	9/1/23

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F 806	Continued From page 61 not honored. Findings include: Review of R21's "Clinical Census," found in the electronic medical record (EMR), under the "Clinical" tab revealed R21 was admitted on 08/05/22 with diagnoses including major depressive disorder and adjustment disorder with anxiety. R21's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/29/23, revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R21 was severely cognitively impaired. A recent Social Service note, dated 06/27/23, revealed the resident now had a BIMS score of 9 out of 15 which indicated moderate cognitive impairment. Review of "Physician Orders," found in the "Clinical" tab of the EMR and dated 09/05/22, revealed an order for "vegetarian diet." Review of the "Food Council" monthly notes revealed, on 03/02/23, R21 reported that she "wants her diet card changed to vegetarian." On 06/26/23 at 1:30 PM, R21 was interviewed in her room. Four peanut butter and jelly sandwiches were observed, in individual packages, on the resident's bookshelf. R21 said "They always give me these, it's always peanut butter and jelly." R21 added, "I'm Jewish, I don't eat meat or fish. They don't follow that; it makes me so mad." On 06/26/23 at 5:58 PM, R21 was observed in	F 806	will be reviewed for accuracy. Dietary Director will be re-educated on resident preferences and meal service. Dietary Director and staff educated on checking tray cards prior to plating meals. Nursing Assistants educated to check tray card before serving meal. Dietary Director/Designee will be responsible for ensuring compliance by checking 5 resident□s preferences to ensure they match tray cards meals weekly audits x 4 and Monthly x 2. Five resident trays will be audited to ensure meal served matches the tray card. Facility QA&A Committee will review audit results.	

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F 806	Continued From page 62 the dining room and had been served a seafood salad sandwich. R21 was heard telling the Nurse Manager for the floor, Registered Nurse (RN) D that, "I cannot eat this." RN D apologized to R21 and told her she would get her what she would eat, not seafood. RN D stated, "I told them [dietary] last week to fix this. They can't get it right." Social Service Assistant (SS) A was also assisting to obtain food the resident would eat as R21 was very upset at receiving the seafood salad sandwich. Review of R21's diet card, under "Notes," revealed that it stated, "Vegetarian, no meat/fish, no veggie meat." The card showed "Dislikes," which were noted at the bottom of the card, and included, "fish/seafood, eggs, meat, all turkey, pork, and chicken." However, under "Starter Items," the diet card list included herb baked fish. In an interview with Culinary Manager (CM) A, on 06/28/23 at 11:30 AM, she said the dietary department could not change the information on the diet card. CM A stated that, "because the resident wants a vegetarian diet, fish and seafood are automatically added." Interview with Registered Dietitian (RD) J and Dietetic Technician (DT) K, on 06/28/23 at 3:30 PM revealed they were able to change R21's diet card. DT K stated she had changed it on 06/28/23 (after surveyor intervention) to reflect that R21 should not receive any fish/seafood. An additional interview with RN D, on 06/29/23 at 9:00 AM, revealed she had been trying to get R21's diet card changed for a while. RN D confirmed that serving fish was upsetting to R21 and that she tried to "catch it" before it is served.	F 806		

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F 806	Continued From page 63 During an observation of the seventh floor dining room on 6/29/23 at 8:49 a.m., residents requiring help to eat were being assisted and all residents in the dining room had been served their breakfast trays except R198 who had been sitting at a table with five empty cups of various beverages that she had drank. R198 left the table and told staff she did not get a meal tray and that she was going to go back to her room. The staff apologized to R198, and R198 left the dining room. During an interview on 6/29/23 at 8:54 a.m., R198 stated she was an early riser and had been sitting in the dining room since approximately 6:45 a.m. R198 stated she liked to take a nap after breakfast and because they did not give her a meal tray after waiting for over two hours, she told the staff she would wait to eat until lunch. R198 stated they liked to eat breakfast, and would have eaten it had she been served, but it had gotten too late in the morning.	F 806		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 808	R52 is being served the proper food.	9/1/23

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F 808	Continued From page 64 review the facility failed to ensure 2 of 2 resident (R52, R143) received ordered, therapeutic diets to maintain or improve their nutritional status. Findings include: Centers for Disease Control and Prevention (CDC) (2022), "Diabetes" indicated keeping blood sugar levels within a healthy target range was important to prevent or delay serious health concerns such as heart and kidney disease. The article indicated a healthy target blood sugar to be 80-130 mg/dL prior to meals and less than 180 mg/dL two hours after the start of a meal. Chronically high blood sugar levels can lead to long-term, serious health problems such as fatigue. R52's significant change Minimum Data Set (MDS) dated 6/16/23, indicated R52 had moderate cognitive deficits and required supervision for eating and extensive assistance with personal hygiene and dressing. R52's diagnoses included encephalopathy (a group of diseases that affect brain structure and/or function), urinary retention, diabetes, and stroke. R52's care plan undated, indicated R52 had a ADL self-care deficit related to chronic encephalopathy and diabetes. Interventions included "NO POP or JUICE." R52 had a mental health disorder related to impulsive eating including taking loaves of bread and multiple sodas from the unit kitchenette. Interventions included closing the kitchenette door as able, setting boundaries, redirecting, and providing informed consent regarding potential consequences of adverse behaviors. The care plan also indicated R52 had a communication	F 808	R143 is being served the proper food and beverages. Residents with special diets orders are at risk for the alleged deficient practice. Dietary Director, dietary staff and nursing assistant staff will be re-educated on following resident diet orders. Dietary Director/Designee will be responsible for ensuring compliance by checking 5 residents meals per week a to ensure resident diet orders are being followed. Weekly Audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 808	Continued From page 65 problem and impaired thought processes related to encephalopathy and was not always able to understand others. Interventions included supervision and assistance with all decision making. R52 also had a nutritional problem related to a stroke, adjustment disorder, heart failure, edema, and diabetes. R52 had a modified diet for glycemic (sugar) control. Interventions included identifying areas of non-compliance, limiting juice and soda, encouraging compliance, and providing the diet as ordered. R52's physician orders dated 5/4/23, indicated R52 took 2000 milligrams (mg) of Metformin (diabetes medication) extended release (ER), and 5 mg of glipizide ER (diabetes medication) once a day for diabetes. The orders also indicated R52 was on a consistent carbohydrate diet (CCHO, to maintain blood sugar levels at a healthy and consistent level). R52's hospital discharge summary dated 11/10/22, indicated R52 was brought from home to the emergency department for urinary retention and altered mental status. R52 was discharged to the facility on 11/13/22, for rehabilitation. R52's hospital Interagency Physician Discharge Orders/Instructions dated 11/7/22, indicated R52 was diagnosed with a stroke. Risk factors included diabetes. R52's hospital Occupational Therapy (OT) discharge recommendations dated 11/7/22, indicated R52 had impaired cognition, was not safe to return home alone, and needed maximum assistance for meal prep. R52's hospital Physical Therapy (PT) Inpatient	F 808		

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F 808	Continued From page 66	F 808		

Initial Evaluation dated 11/10/22, indicated although R52 was married, he and his wife lived in separate homes. R52's wife would visit him daily to give him his daily medications and deliver meals.

R52's Association of Clinical Psychology (ACP) note dated 3/17/23, indicated R52 was referred to ACP to assess strategies to manage behaviors due to medical and mental health and to increase compliance and/or reduce resistance to medical care. R52 had concerns related to fatigue and psychomotor retardation (a slowing of thought processes and physical movements). ACP recommendations included exercise and nutrition.

R52's ACP note dated 4/24/23, indicated R52 stated he continued to feel fatigued and slept throughout the day. ACP recommendations included exercise, nutrition, and stable stimulant usage.

R52's Blood Sugar Summary indicated the following blood sugar levels in milligrams per deciliter (mg/dL):
-6/23/23 at 8:25 a.m., 171
-6/23/23 at 5:18 p.m., 208
-6/24/23 at 10:59 p.m., 186
-6/24/23 at 5:16 p.m., 192
-6/25/23 at 9:07 a.m., 172
-6/25/23 at 5:38 p.m., 165
-6/26/23 at 8:16 a.m., 150
-6/26/23 at 5:56 p.m., 135
-6/27/23 at 8:39 a.m., 424
-6/27/23 at 7:04 p.m. 165
-6/28/23 at 8:22 a.m., 259
-6/28/23 at 5:00 p.m., 220
-6/29/23 at 8:00 a.m., 204

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F 808	Continued From page 67 R52's Nutrition Screen and Assessment dated 5/5/23, indicated R52 was on a CCHO diet and had a history of excessive eating, often requesting six to seven sandwiches per day in addition to his meals. The assessment also indicated juice and soda were limited due to R52's history of diabetes and high blood sugar levels. During an interview on 6/26/23 at 1:17 p.m., R52's family member (FM)-C stated although R52 was not supposed to have soda because he had diabetes, when she visited him the previous day, he had four empty cans of soda and cookies on his bedside table. During an observation on 6/28/23 at 8:57 a.m., R52 was in the resident dining room. R52 ate all of the food on his plate including a dessert cup filled with purple, flavored yogurt and granola. During an interview on 6/28/23 at 9:18 a.m., nursing assistant (NA)-J stated staff were to verify the food on a resident's tray was appropriate for their diet according to their meal ticket. NA-J also stated a resident who had diabetes should not have been served yogurt with granola because it had a lot of sugar. During an observation on 6/28/23 at 2:33 p.m., R52 was sitting in the dining room eating a cup of orange sherbet and drinking a 12-ounce cup of apple juice. R52's meal ticket dated 6/29/23, "Lunch" "***NOTES:*** NO JUICE OR SODA." The ticket also indicated "***STARTER ITEMS*** Choice of Juice [4 fl oz], Milk Skim [8 fl oz], and Milk 1% [4 fl oz]. DIET: Consistent Carbohydrate."	F 808		

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F 808	Continued From page 68 During an observation on 6/29/23 at 8:28 a.m., R52 was in the dining room eating breakfast and drinking a ginger ale soda that was not sugar-free. R52's meal ticket dated 6/29/23, "Breakfast" indicated "*** NOTES:*** NO JUICE OR SODA." The ticket also indicated "***STARTER ITEMS*** Choice of Juice [4 fl oz], Milk Skim [8 fl oz], and Milk 1% [4 fl oz]. DIET: Consistent Carbohydrate." During an interview on 6/29/23 at 8:41 a.m., NA-D verified R52 was drinking soda and stated sometimes R52 asked for soda so they "just give it to him" even though the meal ticket indicated "NO SODA" because he was on a diabetic diet. During an observation on 6/29/23 at 12:40 p.m., R52's meal tray remained at his seat in the dining room. One bite of chicken was gone, and the peach cobbler dessert cup was empty. During an interview on 6/29/23 at 12:42 p.m., R52 was lying in his bed. R52 verified he ate the dessert but wasn't very hungry for anything else that was served. R52 stated eating foods high in sugar didn't "bother" him and was unaware he took medications for diabetes. R52 further shrugged his shoulders and stated he was not aware of the risks or concerns of eating high sugary foods. R52's meal ticket dated 6/28/23, "Lunch" indicated "***NOTES:*** NO JUICE OR SODA." The ticket also indicated "***STARTER ITEMS*** Choice of Juice [4 fl oz], Milk Skim [8 fl oz], and Milk 1% [4 fl oz]. DIET: Consistent Carbohydrate."	F 808		

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F 808	Continued From page 69 The National Institute of Diabetes and Digestive and Kidney Disease (2016) "Eating Right for Chronic Kidney Disease" indicated "The first steps to eating right" were to choose foods with less salt to control high blood pressure. The article also indicated to avoid foods with high phosphorus such as dairy. R143's quarterly MDS dated 5/4/23, indicated R143 had intact cognition and was independent with eating. R143's diagnoses included chronic kidney disease and kidney failure with tubular necrosis (damage and/or death to part of the kidney), morbid obesity, diabetes, foot ulcer related to diabetes, fluid retention, high potassium, urinary retention, high blood pressure, peripheral vascular disease (PVD, decrease circulation to the extremities), vitreous degeneration to the right eye (loss of fluid in the eye resulting in vision loss), and diabetic retinopathy (damage to blood vessels in the eye due to high blood sugar levels, resulting in vision loss). R143's care plan undated, indicated R143 had a communication problem related to vision and hearing impairment. R143 also had a nutritional problem related to failure to thrive, constipation, water retention, low thyroid, a gastric ulcer, kidney disease, high blood pressure, high cholesterol, morbid obesity, and diabetes. Interventions included a dietary consult for ongoing monitoring and nutritional regimen, discussing feelings related to food and self-image, explaining and reinforcing the importance of maintaining the prescribed diet and encouraging compliance. Interventions also included a renal low potassium and CCHO diets.	F 808		

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	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 808	Continued From page 70 R143's preferences included low sodium soups and almond milk and her dislikes included ham, salty foods, juice, and potato chips. Interventions also included providing R143 a diet as ordered. The care plan further indicated R143 had impairment to skin integrity. Interventions included encouraging good nutrition. R143's phsician orders dated 6/22/22, indicated R143 was on a renal/low potassium diet. Meal service details indicated R143 was on a diabetic/renal diet and preferred "chef salad (No ham please)" and "soup of the day LS (LOW SODIUM)." The orders also indicated R143 received insulin Lispro per sliding scale, insulin Glargine 25 units, HumaLog insulin 4 units once daily and HumaLog insulin 3 units once daily for diabetes and 20 mg Lasix (a diuretic) once daily for edema (water retention). The orders also indicated to bring R143 a glass of milk and coffee in the AM at her request. The orders did not specify R143's preference of almond milk. R143's Nutrition Screen and Assessment dated 4/18/23, indicated R143 had significant weight gain likely due to increased lower leg edema as R143 did not believe she was exceeding her suggested daily caloric intakes. R143's meal ticket dated 6/27/23, indicated "***NOTES:*** ALMOND MILK WITH MEALS***RENAL/DIABETIC DIET." "***STARTER ITEMS***" included: Almond Milk, Milk 1%, and a Chef Salad. "DIET: Renal/Low Potassium." "ALERTS: DIABETIC/RENAL DIET. DISLIKES: Rice." During an interview on 6/26/23 at 2:10 p.m., R143 stated she was just recently put on a diabetic diet	F 808		

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F 808	Continued From page 71 although she should have been on it "a long time ago." R143 stated staff were still serving her potato chips, apple juice and hot dogs, even though her meal ticket indicated not to. R143 also stated staff were serving her processed meat, possibly ham or bologna, on her chef salad which was not consistent with her low sodium diet. R143 stated she had mentioned her concerns to staff when they bring her her tray in her room, "but they don't care." During an observation and interview on 6/26/23 at 5:39 p.m., R143 was sitting in her room in a recliner with her meal tray on a table in front of her with what appeared to be "regular" white milk. R143 tasted the milk and verified that it was "regular" milk and not almond milk as she has requested. During an observation and interview on 6/28/23 at 12:36 p.m., R143 was sitting in her recliner in her room with a meal tray on a table in front of her. The meal tray included a cup of ice cream which was not sugar-free and a chef salad with slices of ham. During an observation and interview on 6/29/23 at 12:32 p.m., R143 was sitting in her recliner in her room with her meal tray on a table in front of her. An empty dessert bowl was on R143's tray and her meal ticket indicated it was peach cobbler. R143 stated she ate all of the peach cobbler although she shouldn't have, and she ate the ice cream they served her the previous day because she had a hard time controlling herself. During an interview on 6/28/23 at 2:18 p.m., registered dietician (RD)-A stated RDs entered resident dietary orders and preferences in their	F 808		

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F 808	Continued From page 72 electronic medical record (EMR) and the culinary staff would print the meal tickets with the information on it to accompany their meal trays and ensure they were consistent with the resident's diets. During an interview on 6/28/23 at 2:25 p.m., RD-B stated R143 was on a diabetic and a renal (low sodium) diet. RD-B first assessed R143 in April 2023, due to unwanted weight gain due to water retention in her lower extremities, which was also a reason R143 was on a low sodium diet. RD-B stated R143 tried to watch the calories she ate and "eat well." RD-B verified R143 should not have ham on her chef salad and should not have been served ice cream because R143 wants to lose weight and admits she has "no will power." RD-B also stated R52 should not have been served a 12 ounce cup of apple juice. RD-B also stated R52 was moderately impaired, and although she had spoken to him about not drinking soda, RD-B had not spoken to FM-C regarding his non-compliance. RD-B further stated, often staff offer snacks to all the residents, including ice cream, and staff may not be aware of resident dietary restrictions during that time. During an interview on 6/29/23 at 2:24 p.m., the director of nursing (DON) stated staff were expected to look at the meal tickets and ensure the meal they are serving a resident is consistent with their listed restrictions and preferences. The DON also verified the meal tickets were conflicting and may have made it difficult for staff to understand what the resident's restrictions and preferences were. The facility Diet Orders policy dated 11/28/17, indicated there was to be ongoing communication	F 808		

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F 808	Continued From page 73 and coordination within all departments to ensure residents food, hydration, and nutrition services meet the daily dietary needs and choices of the residents.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, and review of the Food and Drug Administration (FDA) Code, the facility failed to assure food was stored, prepared, and served in a sanitary manner. Foods were not dated and /or labeled, covered, and disposed of after expiration. Equipment/surfaces were not clean or were not in good repair. These failures had the potential to increase the risk of food borne illnesses and affect 199 of 206 residents living at	F 812	Food was disposed of and areas were cleaned. Residents□ food storage will be checked during a building wide review to ensure that all food items are stored or disposed of properly. Dietary Director and kitchen staff will be re-educated on proper food storage.	9/1/23

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F 812	Continued From page 74 the facility who received food from dietary services. Findings include: Review of the, undated, policy titled "Food Storage," provided by the facility on 06/29/23, revealed: "Dry Storage: All items shall be dated and labeled when needed. (items that have manufacturer expiration dates, will be considered dated.) Items that are fresh for that meal or shift, - i.e., resident meal, resident drhks [drinks] will not need to be individually dated ... Opened items will have a date reflecting the date that item was opened on if manufacturer sets open limit. ... Items will be covered and/or wrapped." "Refrigerated Storage: All Foods should be covered, labeled, dated." "Policy and Procedure Manual: Food Storaoe [storage]- Items [items] that may lose quality if stored for a longer period, but will still be safe, may be repurposed to other uses. (i.e., croutons, pureed additions, etc.)." "Procedure: Items sent fresh each meal or each shift, will be associated with that date." 1. An initial observation of the facility kitchen was conducted, along with Sous Chef B, on 06/26/23 from 12:15 - 12:50 PM. The tour included the following observations: a. The following items were observed on a stainless steel cart in a walk in refrigerator: a stainless steel container of tuna salad, dated 06/20; a stainless steel container of strawberries, undated; a stainless steel container of peeled oranges, undated; a stainless steel container of chopped bacon, undated; and a container of	F 812	Dietary Director/Designee will be responsible for ensuring compliance by randomly checking 5 different kitchen areas with Weekly audits x 4 and Monthly x 2. Facility QA&A Committee will review audit results.	

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F 812	Continued From page 75 shredded carrots, dated 06/19. Sous Chef B did not explain why the items were undated and/or how long food items were kept before disposal. b. Stored in the refrigerator were the following: a stainless steel container of unlabeled food and liquid, identified as cooked black beans by Sous Chef B, dated 06/20; a ¾ full pitcher of orange juice, undated; a ¼ full pitcher of orange juice, undated; a full pitcher of apple juice; and a ¼ full pitcher of cranberry juice. Sous Chef B stated, "I assume they're from breakfast." c. On an open shelving unit, in a second walk in refrigerator, the following was observed: an open container of creamy Caesar dressing, dated 04/14; an open container of mayonnaise, undated; an open container of mustard, undated; an open container of Bar-B-Q sauce, undated; an open ½ gallon container of whole milk, undated; an open container of yogurt, undated; an open container of Franks hot sauce, undated; two open containers of stir fry sauce, undated; an open container of lemon juice, expired 05/23; an open bottle of soy sauce, undated; an open container of sesame dressing, expired 03/23; an open container of coleslaw dressing, expired 03/13/23; two open containers of beef base, undated; an open container of "garlic in water," undated; two open containers of whipping cream, undated. In response to the undated and expired items, Sous Chef B stated, "We'll have to do better." d. Observations in the freezer revealed the following: cooked hashbrowns, illegible date; leftover frozen lasagna with torn aluminum foil as a cover, dated 06/24; a pan of cooked frozen lasagna, dated 05/24; two packages of frozen donuts, 40 in total, undated, unlabeled; pureed	F 812		

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F 812	Continued From page 76 pancakes, dated 03/02/23; icing, dated 05/18; chocolate cream, dated 03/31; and a pan of cooked brownies, loosely covered with plastic wrap, dated 03/08. Sous Chef B stated he "planned to use the brownies for puree at some time." e. Observations of the dry storage area revealed three large stainless steel containers, approximately two feet high by one foot wide. The containers with flour and sugar each had a scoop inside. A 12 quart plastic container, approximately half full of white rice, had a scoop inside. A 12 quart plastic container, approximately half full of powdered sugar, had a scoop inside. A plastic bag, containing dry cereal, was tied in a knot to close, but was not sealed. f. An approximate 26 inch section of baseboard tile, in the dry storage area, was observed to be heavily damaged, had missing tiles, and deep gouges in the wall. There was a gap, measuring approximately one inch wide, across the entire floor of the dry storage area. The gap had no grout allowing dirt and food particles to collect. The wall, on the opposite side of the dish room, had an area measuring approximately 36 inches by 15 inches with a gouge/groove around the area which was unpatched and unpainted. A hole, measuring approximately 4 inches by 2 inches, was located at the bottom of the wall exposing the inside of the wall. 2. A second inspection of the kitchen, on 06/28/23 at 11:45 AM, was completed with Culinary Manger (CM) A. The following conditions remained the same in the freezer as first observed on 06/26/23: cooked hashbrowns,	F 812		

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F 812	Continued From page 77 illegible date; leftover frozen lasagna with torn aluminum foil as a cover, dated 06/24; a pan of cooked frozen lasagna, dated 05/24; two packages of frozen donuts, 40 in total, undated, unlabeled; pureed pancakes, dated 03/02/23; icing, dated 05/18; chocolate cream, dated 03/31; and a pan of cooked brownies, loosely covered with plastic wrap, dated 03/08. The pan of brownies was noted to be light in color across areas of the pan and had freezer burn on the edges where it was not completely covered with the plastic wrap. Review of the FDA Code 2022, revealed: "Ready-to-ear, Time/Temperature Control for Safety Food: prepared and held in a Food Establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .... Date marking is the mechanism by which the Food Code requires active managerial control of the temperature and time combinations for cold holding. Industry must implement a system of identifying the date or day by which the food must be consumed, sold, or discarded. Date marking requirements apply to containers of processed food that have been opened and to food prepared by a food establishment, in both cases if held for more than 24 hours, and while the food is under the control of the food establishment... A date marking system may be used which places information on the food, such as on an overwrap or on the food container, which identifies the first day of preparation, or alternatively, may identify the last day that the food may be sold or consumed on	F 812		

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F 812	Continued From page 78 the premises. A date marking system may use calendar dates, days of the week, color-coded marks, or other effective means, provided the system is disclosed to the Regulatory Authority upon request, during inspections." 3. Observations of the "kitchenettes," on the 2nd, 3rd, 5th, 6th, and 7th floors, revealed the following: a. Observation of the 2nd floor kitchenette, on 06/29/23 at 12:04 p.m., revealed four 1/2 gallon containers of opened milk. Two containers were skim milk and two containers were whole milk. None of the containers were dated as to when they were opened. b. Observation of the 3rd floor kitchenette, 06/29/23 at 12:10 p.m., revealed two opened ½ gallon milk containers. One container was whole milk, and one container was skim milk. Neither container was dated as to when it was opened. c. Observation of the 5th floor kitchenette, on 06/29/23 at 12:33 p.m., revealed three self-serve containers of dry cereal, undated as to when the cereals were opened and placed in the containers. The cereals were identified, on the container, as "rice crunchins," cheerios, and corn flakes. The lid of the corn flakes was off the container. In addition, the microwave in the kitchenette was dirty with dark spills on the plate and bottom of the microwave. d. Observation of the 6th floor kitchenette, on 06/28/23 at 7:31 a.m., revealed six undated one-gallon containers, three skim milk and three whole milk; an undated open ½ gallon of almond	F 812		

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F 812	Continued From page 79 milk; three loaves of undated open sliced bread; an undated open container of brown sugar; an undated open container of peanut butter; a self-serve container of cheerios dated 03/01/22; an open undated self-serve container of rice cereal; an open self-serve container of corn flakes dated 08/01/22; an open undated container of raisin bran cereal; an open container of "European style whipped margarine butter blend," five pounds, open and undated which read "keep refrigerated." The butter blend was located on the cabinet shelf, unrefrigerated. In addition, the vent above the refrigerator had a heavy build-up of dirt, dust, and grime. A dirty toaster was filled with breadcrumbs throughout the appliance; and a wall fan located above the coffee maker which had a heavy buildup of dust, dirt, and grime. The fan was turned on and was oscillating over the coffee maker, self-serve cereal containers, and the container of silverware placed on the counter. An additional observation of the 6th floor kitchenette, on 06/29/23 at 12:37 p.m., revealed the same conditions as previously observed on 06/28/23 at 7:31 AM. In addition, observation of the refrigerator revealed an opened, undated 46 fluid ounce container of prune juice; and an opened undated 32 ounce container of Med Pass 2.0 vanilla shake flavor. e. Observation of the 7th floor kitchenette, on 06/29/23 at 12:47 p.m., revealed two undated plastic containers of dry cereal on the cabinet shelf. During interview on 06/29/23 at 1:30 PM with culinary manager (CM)-A revealed that the kitchen staff were responsible for cleaning the kitchenettes and making sure items were dated.	F 812		

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F 812	Continued From page 80 Review of the "Daily Serving Kitchen Checklist" provided by CM-A, on 06/29/23 at 2:26 PM, revealed staff were to clean all counters; clean toaster, remove toaster crumbs and toaster table; organize cabinet, condiments, stock for next meal; clean microwave; wipe and polish the outsides of cabinet doors; wipe out drawers when dirty; make sure all open packages are in airtight containers; record cooler and freezer temperatures; throw away any outdated foods or beverages; and label all foods not stored in their original packaging. Document review on 6/27/23, of the seventh floor kitchenette Refrigerator and Freezer Temperature Sheet (first refrigerator) dated June 2023, indicated the following refrigerator temperatures in Fahrenheit (F): 6/1/23, 29 6/2/23 to 6/5/23, no temps recorded 6/6/23, 43 6/7/23 to 6/8/23, 40 6/9/23, no temp recorded 6/10/23, 40 6/11/23-6/12/23, no temps recorded 6/13/23, 40 6/14/23, no temp recorded 6/15/23, 29 6/16/23, 40 6/17/23, no temp recorded 6/18/23, "Not Working" 6/19/23 to 6/20/23, no temps recorded 6/21/23, 40 6/22/23, no temp recorded 6/23/23, 28 6/24/23, 40 6/25/23, 38	F 812		

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F 812	Continued From page 81	F 812		

No further temperatures were recorded.

Document review on 6/27/23, of the seventh floor kitchenette Refrigerator and Freezer Temperature Sheet (second refrigerator) dated June 2023, indicated the following refrigerator temperatures in Fahrenheit:

6/1/23, 45
6/2/23, no temp recorded
6/3/23, 50
6/4/23 to 6/5/23, no temps recorded
6/6/23, 45
6/7/23, 40
6/8/23, 49
6/9/23, 50
6/10/23, 50
6/11/23 to 6/12/23, no temps recorded
6/13/23, 50
6/14/23 to 6/15/23, no temps recorded
6/16/23, 45
6/17/23, "Not working good"
6/18/23 to 6/19/23, no temps recorded
6/20/23, 50
6/21/23, 41
6/22/23, no temp recorded
6/23/23 to 6/25/23, 50
No further temps were recorded.

During an observation on 6/7/23 at 8:33 a.m., various milk cartons and juice pitchers were in two tubs with ice, awaiting breakfast service. It was unknown where the beverages had been stored prior to being placed in the tubs. The second refrigerator contained 10 pitchers of various juices including apple, orange, and cranberry.

During an interview on 6/27/23 at 9:09 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 82 dietary aid (DA)-A stated the dietary staff was responsible for checking the refrigerator temps every day. DA-A stated the refrigerator temperature was supposed to be 40 degrees F. DA-A stated there was no range for the required temperature. During an observation and interview on 6/7/23 at 9:13 a.m., the culinary manager (CM) stated the refrigerator temps were to be 40-41 degrees F. The CM verified the second refrigerator thermometer indicated the temperature was 50 degrees F and it was too warm. The CM further stated she was unaware the refrigerators were not working correctly, and staff should have notified her and maintenance the first time the refrigerator temperature was out of the acceptable range and when the refrigerators weren't working properly.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		9/1/23

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F 880	Continued From page 83 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 84 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, and review of facility policy, the facility failed to have an effective system in place to prevent the spread of infection. The facility failed to have a complete water management program that was consistent with the current ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) Guideline, which specifically called for documentation of design and maintenance procedures to protect from the potential exposure of Legionnaire's disease (a serious pneumonia infection) within a healthcare facility. This failure created a potential for 193 of 206 facility residents, who were over the age of 65, to be infected by Legionella. In addition, the facility failed to ensure 2 nursing assistants (NA) appropriately sanitized their hands by using soap during hand washing, prior to serving drinks to residents. The facility also failed to ensure 1 of 1 resident (R- 198) maintained infection control practices when assisting another resident, (R153), with her breakfast meal. Findings include: 1. Review of a policy provided by the facility titled	F 880	The facilities water systems are free of Legionella and systems are in place for on-going monitoring. Staff education initiated regarding handwashing during meal service. Staff educated to re-direct residents when touching other resident□s food. Nurse re-educated regarding the necessity of wearing gloves with eye drop administration. Documentation is being completed for the Legionella program Residents have the potential to be affected if staff/residents do not perform appropriate handwashing prior to serving meals/touching food or wearing gloves when administering certain medications. Maintenance staff have been educated regarding the documentation of Legionella testing and monitoring in the appropriate log.	

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F 880	Continued From page 85 "Legionella Water Management Program," reviewed 09/2022, revealed, ""3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 4.The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program." Review of website for ASHRAE titled "Risk Management for Legionellosis" dated 10/2015 indicated "The design engineer first needs to evaluate which requirements of the standard apply to their project. This evaluation determines if the project contains any of the following building risk factors. . .Health-care facility with patient stays over 24 hours. . .Facilities designated for housing occupants over age 65. . .The risk of disease or illness from exposure to Legionella bacteria is not as simple as the bacteria being present in a water system. Other factors that contribute to the risk are environmental conditions that promote the growth and amplification of the bacteria in the system, a means of transmitting these bacteria (via water aerosols generated by the system), and the ultimate exposure of susceptible persons to the colonized water that is inhaled or aspirated by the host providing a pathway to the lungs. The bacteria are not transmitted person-to-person, or from normal ingestion of water. Susceptible persons at high risk for legionellosis include, among others, the elderly, dialysis patients, persons who smoke, and persons with medical conditions that weaken the immune system."	F 880	Nursing staff have been educated on the appropriate handwashing required prior to and during meals as well as wearing clothes when administering certain medications. Infection Control Nurse/Designee will be responsible for ensuring compliance by random Weekly audits of Legionella documentation to ensure it is in place x 4 and Monthly x 2. Five handwashing observations will be done before and during meal service Weekly X 4 and Monthly X 2. Observations of 5 meal services to ensure residents are not touching each other□s food. Eye drop administration will be observed 5 times weekly to ensure correct procedure is followed. Facility QA&A Committee will review audit results.	

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F 880	Continued From page 86 Review of the Centers for Disease Control and Prevention (CDC) website titled "Legionella. . .Prevention and Control, dated 03/25/21, revealed, "The key to preventing Legionnaires' disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella. . .Key Elements. . .Seven key elements of a Legionella water management program are to. . . Establish a water management program team. . . Describe the building water systems using text and flow diagrams. . . Identify areas where Legionella could grow and spread. . . Decide where control measures should be applied and how to monitor them. . . Establish ways to intervene when control limits are not met. . . Make sure the program is running as designed (verification) and is effective (validation). . .Document and communicate all the activities. . .Principles. . . In general, the principles of effective water management include. . .Maintaining water temperatures outside the ideal range for Legionella growth. . .Preventing water stagnation. . .Ensuring adequate disinfection. . .Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella. . .Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met." During an interview with infection control preventionist (ICP)-D on 06/29/23 at 2:16 p.m., she stated all matters pertaining to the facility's Legionella prevention program were deferred to the Maintenance Director. ICP D further stated she had been the facility's ICP for 4-5 years and	F 880		

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F 880	Continued From page 87 had never had anything to do with the facility's legionella program nor did she monitor Legionella as part of the facility's infection control program. ICP D stated she could not recall if Legionella had ever been discussed during Quality Assurance and Performance Improvement meetings. During an interview on 06/29/23 at 3:51 p.m., with maintenance director (MD)-A, he stated there was no documentation or log of times and dates that legionella monitoring activities were performed, nor did he document the facility's testing of its water systems, although he stated it was being done. (MD)-A provided documentation that the cooling tower was tested for legionella on 4/28/23 and 6/18/23 respectively which returned negative for legionella; however, he had no further documentation of testing prior to those dates. (MD)-A further stated there was a legionella risk assessment done by their testing company four years prior but did not provide the documentation of this assessment prior to exit. Interview with maintenance engineer (ME)-B on 06/29/23 at 3:54 p.m., revealed he walked the entire facility to flush stagnant water in unused plumbing at least monthly; however, he did not document this activity, adding that he never thought of documenting as part of his job. 2. Review of a policy titled "Handwashing - Hand Hygiene" dated 03/16/20 indicated "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." a. During a random observation conducted on 06/23/23 at 12:42 p.m., nursing assistant (NA)-A	F 880		

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F 880	Continued From page 88 walked to the sink located on the third-floor transitional care unit's dining area. NA-A turned the water on and placed her hands under the running water. NA A was observed not to use hand soap. NA A then began to place napkins on the tables for resident use. During this time, NA-A was also observed to pass juice out to the residents who were present in the dining area. NA-A was observed continuing this practice until 12:56 p.m.hen she touched the left side of her face mask, NA- then failed to sanitize her hands and continued to pass drinks to the residents. b. During an observation on 06/27/23 at 9:03 a.m. the second-floor secured unit, R198 was observed to pick up the completed meal dishes from each resident and take the plates to a sink located in the same area. R198 was observed to wash each dish and then stack them on a three-tiered chart. R198 then proceeded to wash glasses and bowls and stack them around the sink. At 9:13 a.m resident returned to a table in the dining area and took R153's plate which contained an uneaten hard-boiled egg. R198 placed her bare fingers on R153's plate and wiped the Cheerios from the plate onto a napkin. R198 then took the plate from the resident and washed it in the sink. R153 proceeded to eat the Cheerios off the napkin. Although there were staff present during this observation, no one intervened. During an interview on 06/28/23 at 7:18 a.m., licensed practical nurse (LPN)-A confirmed R198 assists with the removal of plates from the residents after dining. LPN-A stated they try to keep an eye on F198, but she was fast and difficult to redirect. LPN A stated R198 taking the plate from R152 and using her bare fingers to	F 880		

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F 880	Continued From page 89 remove the Cheerios from her plate, as well as allowing R512 to then eat the Cheerios would be an infection control issue. During an interview on 06/29/23 at 9:10 a.m., infection control preventionist (ICP)-D stated staff were to wash or sanitize their hands prior to distributing food/drinks to the residents. ICP-D stated she was not aware R198 would assist the staff with cleaning up the dishes after resident use. During an observation of the seventh floor dining room, on 6/29/23 at 8:41 a.m., nursing assistant (NA)-D took multiple meal trays out of the insulated cart and served them to residents in the dining room without wearing gloves. NA-D carried a chair from one table and placed it between two residents who required assistance to eat and put a clothing protector on one of the residents. NA-D touched the shoulder of the other resident to wake them up, then immediately assisted the other resident to drink apple juice from an open cup without first performing hand hygiene. NA-D then sat between the two residents and began assisting them to eat their breakfast without performing any hand hygiene. During observation and interview on 6/29/23 at 7:53 a.m., registered nurse (RN)-E administered eye drops and nasal spray to a resident without wearing gloves. RN-E performed hand hygiene before administration but not after. RN-E stated, "I know, I should be wearing gloves" while administering the medications. During an interview on 6/29/23 at 9:34 a.m., the	F 880		

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F 880	Continued From page 90 infection control preventionist (ICP) stated the expectation is to wear gloves when administering eye drops or nasal spray and to perform hand hygiene before and after administration. No policy related to hand hygiene was received by the end of the survey.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		9/1/23

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F 883	Continued From page 91 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, document review, and review of Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to revise their pneumococcal vaccine policy to reflect current pneumococcal vaccination guidelines. This failure increased the risk for residents to not be vaccinated per current guidelines and contract pneumonia. Findings include: Review of a policy provided by the facility titled "Pneumococcal Vaccines," dated 12/2017,	F 883	Facility Pneumococcal Policy & Procedure has been updated. The Facility will follow current CDC guidelines on the scheduling and administration of Pneumococcal Vaccines. CDC website will be audited monthly X 4 to ensure there has been no updates to pneumococcal vaccine recommendations. Policy will be revised and updated in the event of any further CDC guidance changes.	

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F 883	Continued From page 92 indicated "All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Both 23-valent pneumococcal polysaccharide (PPSV23®) and 13-valent pneumococcal conjugate (PCV13®) vaccines will be administered routinely in series to all adults >65 years. Adults who are immunocompromised and aged 65 years or older should receive PCV13 followed by PPSV23 at least 1 year after PCV13." Review of the Center of Disease Control (CDC) website titled "Pneumococcal Vaccination: Summary of Who and When to Vaccinate," last reviewed 01/24/22, indicated "CDC recommends pneumococcal vaccination for all adults 65 years or older. The tables below provide detailed information . . . For adults 65 years or older who have not previously received any pneumococcal vaccine, CDC recommends you . . . Give 1 dose of PCV15 or PCV20 . . . If PCV15 is used, this should be followed by a dose of PPSV23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . . . If PCV20 is used, a dose of PPSV23 is NOT indicated . . . For adults 65 years or older who have only received a PPSV23, CDC recommends you . . . May give 1 dose of PCV15 or PCV20 . . . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults 65 years or older who have only received PCV13, CDC recommends you . . . Give PPSV23 as previously recommended. . . For adults who have received PCV13 but have not completed	F 883	The Infection Preventionist has received education on the CDC guidelines of Pneumococcal Immunization. Director of Nursing/Designee will be responsible for ensuring compliance with resident immunization with the updated policy with 5 random residents with Weekly audits x 4 and Monthly x 2. Existing resident wills be audited at care conference for compliance. Facility QA&A Committee will review audit results.	

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F 883	Continued From page 93 their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete." The CDC guidelines went into effect on 10/21/21 per recommendations from the Advisory Committee on Immunization Practices (ACIP). During an interview on 06/29/23 at 9:10 a.m., the infection control preventionist (ICP)-D stated the facility's current pneumococcal policy needed to be updated to reflect the current CDC recommendations.	F 883		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a sanitary and homelike environment for 3 of 3 residents (R10, R59, R135) whose tube feeding poles and equipment had dried tube feeding residue on them. Findings include: R10's Admission Record dated 6/28/23, indicated R10 was admitted on 11/1/2004. Diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (brain tissue damage related to lack of blood flow), aphasia (a language disorder that affects a person's ability to communicate), hemiplegia (paralysis of one side	F 921	R10 & R59 have had tube feeding pumps and poles cleaned of dried tube feeding solution. Residents currently receiving enteral feeding have had their pumps checked. Licensed nursing staff have been educated on the expectations to clean/change out pumps/poles when soiled. Director of Nursing/Designee will be responsible for ensuring compliance by random Weekly audits of the cleanliness of tube feeding pumps and poles x 4 and	9/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 94 of the body), and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting left non-dominant side. R10's quarterly Minimum Data Set (MDS) dated 3/13/23, indicated R10 had severe cognitive impairment, received enteral feeding via gastric tube, and was totally dependent on staff for all activities of daily living. R10's Order Summary Report indicated "Enteral Feed order two times a day, Glucerna 1.5 at 45 ml/hr [milliliters per hour] for 22 hours daily. Stop tube feeding from 3:30 p.m.-5:30 pm. Monitor for s/sx [sign/symptoms of] intolerance." The Order Summary Report also directed staff to flush gastric tube with 30 ml of water before and after each medication administration, and to flush gastric tube with 275 ml of water every four hours for hydration. R10's care plan revised on 9/28/22, indicated R10's required gastric tube feeding related to dysphagia due to a cerebral infarction. R10's care plan goal indicated, F10 will remain free of side effects or complications related to tube feeding. During observation on 6/26/23 at 1:36 p.m., R10 was receiving enteral nutrition at 45 ml/h. A bottle of Glucerna 1.5 hung from a feeding. The tube feeding pump and the pole had several spots of yellow ochre, tube feeding-like dry matter. During further observations on 6/26/23 at 4:49 p.m., 6/27/23 at 8:40 a.m., and 6/28/23 at 8:09 a.m. the tube feeding pump and the pole remained stained with several spots of dried matter.	F 921	Monthly x 2. Facility QA&A Committee will review audit results.	

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	245055	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 921	Continued From page 95 During observation on 6/28/23 at 8:17 a.m. R10's feeding pump was beeping, and the screen displayed a "feed error" alert. The feeding pump and the pole had several yellow colored spots of dry matter. During interview on 6/28/23 at 8:19 a.m. conducted on R10's room, the nurse manager (RN)-D stated the tube feeding pump and pole should be cleaned. R59's Admission Record dated 6/28/23, indicated R59 was admitted to the facility on 8/3/19, and included diagnoses of quadriplegia (paralysis of all four limbs), disease of spinal cord, dysphagia, adjustment disorder with mixed anxiety and depressed mood. R59's quarterly Minimum Data Set (MDS) dated 5/19/23, indicated R59 was cognitively intact, received enteral nutrition and was totally dependent on staff members for activities of daily living. R59's Order Summary Report indicated, "Enteral feeding Order, provide Jevity 1.5 75 ml/h for 12 hours. On at 2100, off at 0900 daily. Monitor for signs and symptoms of tolerance." Orders also indicated to administer 60 ml of water flushes every 6 hours and to flush tube feeding with 30 ml of water "before and after tube feed". R59's Enteral care plan revised on 5/20/22 indicated, R59 required tube feeding related to muscle weakness, contractures, dysphasia, history of malnutrition and anemia. R59's care	F 921		

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F 921	Continued From page 96 plan indicated "the resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders." During observation on 6/26/23 at 12:50 p.m. R59 was in bed. On the left side of the bed was a tube feeding pole with a feeding pump. The tube feeding pump and the pole were dirty with several yellow spots of dry matter, and the pole's base was also dusty. During observation on 6/27/23 at 8:10 a.m., R59's tube feeding pump and pole remained dirty with several spots of dry matter. During interview on 6/28/23 at 8:19 a.m., the (RN)-E stated the tube feeding pump and pole are expected to be cleaned. R135's Clinical Resident Profile printed on 6/29/23 indicated, R135 was admitted on 12/10/20, and diagnoses included hemiplegia and hemiparesis following cerebral infarction right dominant side. R135's quarterly Minimum Data Set (MDS) dated 4/19/23, indicated resident had severe cognitive impairment, received enteral feeding, and needed assistance with all activities of daily living. R135's Order Summary Report dated 7/3/23 indicated, "enteral feed Glucerna 1.5 at 75 ml/hr at 1800 for 16 hours and stop at 1000daily via PEG. Monitor for signs and symptoms of intolerance and notify RD [registered dietician] with any concerns". Enteral orders also directed staff to provide fluid flushes of 250 ml every 3 hours, and to change syringe daily every night	F 921		

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F 921	Continued From page 97 shift." During observation on 6/26/23 at 6:34 p.m. R135 was in bed and there was a tube feeding pole with a pump positioned next to R135. The tube feeding pump had several spots of yellow, tube feeding-like dry matter and tube feeding pole also had the same-colored dried stains running down to the base. During interview on 6/28/23 at 8:19 a.m., (RN)-D verified the tube feeding pole and the pump were dirty and stated, "it should be cleaned". During interview on 6/28/23 at 1:53 p.m. DON stated the tube feeding pumps and poles should be kept clean per standards of practice. The policy titled Enteral Tube Feeding via Gastrostomy/Jejunostomy revised on 7/22/16 indicated, "Gastrostomy/Jejunostomy feeding solution shall be administered through an enteral tube per a physician's or nurse practitioner's orders by a license nurse. Resident privacy, infection control and documentation standards will be maintained per Walker Methodist policies and procedures."	F 921		

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**06/28/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/28/2023. At the time of this survey, Lakehouse Healthcare and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakehouse Healthcare and Rehabilitation Center is an 8-story building with a full basement. The building was constructed at 2 different times. The original 5 story building was constructed in 1964 and was determined to be of Type II(222) construction. In 1983, an 8 story addition was constructed to the North that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was	K 000		

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K 000	Continued From page 2 surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 260 beds and had a census of 206 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell access per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 19.2.2.2.5.2, and 7.2.1.5.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM,	K 225	Keypads at the stairwells are to be remounted below the maximum height of 48 inches. Future keypad work will be below maximum height requirements. Director of Maintenance and/or designee will monitor and maintain compliance with regulation as required in NFPA 101, (2012	9/1/23

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K 225	Continued From page 3 it was revealed by observation that the keypads located at the stairwells in the facility used to unlock the door to gain access to the stairwell were mounted higher than the maximum height of 48 inches. An interview with the Administrator, the Maintenance Director, and the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 225	Edition).	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that the facility did not have documentation showing that they have been testing the emergency lighting, and I located two battery-operated emergency lights on the lower level. An interview with the Administrator and Maintenance Director verified these deficient	K 291	Emergency Lighting will be tested monthly. Emergency light locations and testing log added to fire book. Director of Maintenance and/or designee will monitor and maintain compliance with this regulation as required in NFPA 101, (2012 Edition).	9/1/23

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K 291	Continued From page 4 findings at the time of discovery.	K 291		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and/or install proper exit signage under NFPA 101 (2012 edition), Life Safety Code sections 19.2.10.1, 7.10.1.2.2, 7.10.83, 7.10.8.31 and 7.10.8.3.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that the door leading to the second floor courtyard off the Beauty Shop was missing a "NO EXIT" sign. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 293	No exit sign in Beauty Shop. Sign ordered and to be installed on or before 09/01/23. Director of Maintenance and/or designee will have a new EXIT sign installed in Beauty Shop as required in NFPA 101, (2012 Edition).	9/1/23
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		9/1/23

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K 321	Continued From page 5 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain three hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, and 8.3.3.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 321	Self-closing hinges to be added to door entering the storage room on 1st floor in Raines building. Hinges have been ordered and will be installed on or before 09/01/23. Director of Maintenance and/or designee will have installed and maintained as required in NFPA 101, (2012 Edition).	

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K 321	Continued From page 6 1. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that the unoccupied floors in the Rains building were being used as storage. There was storage in the hallways and resident rooms that did not have self-closing devices on the doors. 2. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that resident room 156 was being used to store boxes of masks and gloves and the door did not have a self-closing device installed on it. An interview with the Administrator, Maintenance Director and the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		7/12/23

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K 324	Continued From page 7 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that the facility did not have documentation showing the kitchen hood suppression system inspection was up to date the last date they had the kitchen hood suppression system inspected was 05/04/2022. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 324	Hood suppression system inspection service completed on 7/12/23. Vendor is now on a regular schedule to complete hood suppression system inspection as required by NFPA 101, (2012 Edition). Maintenance Director and/or designee will monitor and document kitchen hood suppression system inspections going forward.	
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		9/1/23

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K 345	Continued From page 8 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that the fire alarm annuncaitor was showing that the system was in ground fault at the time of the survey. The Maintenance Director stated that they had a service technician scheduled to look at the ground fault that day. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 345	Alarm Panel had a ground fault started morning of 6/28/23. Integrated Fire and Security serviced fire alarm system 6/28/23. The Director of Maintenance and/or designee is responsible for reviewing and maintaining fire alarm inspections and documentation as required in NFPA 101, (2012 Edition).	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		9/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**06/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 9 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.1.1 and 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.4.1, 4.1.4.2, 5.2.1.2, 5.2.1.1.2, 5.2.1.1.4, 5.3.1.1.1.3, and NFPA 13 (2010 edition), Standard for the installation of Sprinkler Systems, sections 8.6.5.3.2 and 8.15.9. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that on the annual fire sprinkler inspection report the technician stated that the sprinkler heads on the second floor were older than 20 years and should either be replaced or a sample of them should be sent out for testing, and the facility could not provide documentation	K 353	1. Sprinkler heads over 20 years old on Annual 7/25/2022 inspection report. Summit replaced some heads on 11/7/22 as per hand written note. Have requested the invoice for verification. Summit sending info on 20 year heads on 2R. Summit annual inspection being completed on 8/2/23 having entire fire sprinkler system rechecked/repaired as needed. 2. Sprinkler Escutcheons missing and dusty LL Breakroom, 3. L25 Escutcheon missing 4. Outside 158, sprinkler heads Dusty Corrosion Escutcheons have been ordered and will be installed. Heads will be fully cleaned. Corrosion is being checked by Summit 8/2/23 5. Storage within 18 inches of ceiling: 6W20 corrected and to be rechecked	

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K 353	Continued From page 10 showing that either had been completed. 2. On 06/28/2023 at 10:19 AM, it was revealed by observation that the four sprinklers located in the employee break room on the lower level had missing escutcheon plates and were fully loaded with dust. 3. On 06/28/2023 at 10:23 AM, it was revealed by observation that the escutcheon plate was missing for the sprinkler located in the oxygen room (L25) on the lower level. 4. On 06/28/2023 at 12:02 PM, it was revealed by observation that there was dust and corrosion on the sprinkler located outside room 158. 5. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in: 1. 6th Floor - Room 6W20 2. 6th Floor - Room 6W15 3. 5th Floor - Room 5W17 4. 2nd Floor - Room 2W15 5. 1st Floor - Thomas Gaetz Office An interview with the Administrator, Maintenance Director, and Maintenance Supervisor verified these deficient findings at the time of discovery.	K 353	6W15 corrected and to be rechecked 5W17 corrected and to be rechecked 2W15 corrected and to be rechecked 1st floor Thomas Gaetz office corrected on 6/29/23 Signage will be added Maintenance staff cleaned the sprinkler heads throughout the facility as needed. Summit Fire Protection was contracted to inspect and replace the corroded sprinkler heads located throughout the facility as needed. The Director of Maintenance and/or designee is responsible for the monitoring and maintaining dirty and/or corroded sprinkler heads and delegating corrective action as necessary as required in NFPA 101, (2012 Edition).	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction	K 372		9/1/23

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K 372	Continued From page 11 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 06/28/2023 at 11:32 AM, it was revealed by observation that there was a penetration caused by low voltage wires that were not fire-stopped in the smoke barrier near resident room 312 above the smoke barrier doors. 2. On 06/28/2023 at 11:32 AM, it was revealed by observation that there was a penetration caused by low voltage wires that were not fire-stopped in the smoke barrier near resident room 333 above the smoke barrier doors. 3. On 06/28/2023 at 11:32 AM, it was revealed by observation that there were penetrations that were not fire-stopped in the smoke barrier on the 7th Floor - next to door 7W13.	K 372	Smoke Barriers located by the rooms as follows: 1. By 312 2. by 333 3. by 7W13 4. by 7W25 5. by 6N25 6. By 535 7. by 435 8. by 4N32 9. by 231 Smoke barriers checked and penetrations sealed properly. Director of Maintenance and/or designee will monitor and maintain all facility smoke barriers from having unsealed openings.	

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K 372	Continued From page 12 4. On 06/28/2023 at 11:32 AM, it was revealed by observation that there were penetrations that were not fire-stopped in the smoke barrier on the 7th Floor - next to door 7W25. 5. On 06/28/2023 at 11:32 AM, it was revealed by observation that there were penetrations that were not fire-stopped in the smoke barrier on the 6th Floor - next to door 6N25. 6. On 06/28/2023 at 11:32 AM, it was revealed by observation that there were penetrations that were not fire-stopped in the smoke barrier on the 5th Floor - Room 535. 7. On 06/28/2023 at 11:32 AM, it was revealed by observation that there were penetrations that were not fire-stopped in the smoke barrier on the 4th Floor - Room 435. 8. On 06/28/2023 at 11:32 AM, it was revealed by observation that there were penetrations that were not fire-stopped in the smoke barrier on the 4th Floor - next to door 4N32. 9. On 06/28/2023 at 11:32 AM, it was revealed by observation that there were penetrations that were not fire-stopped in the smoke barrier on the 2nd Floor - next to Office 231. An interview with the Administrator, Maintenance Director, and Maintenance Supervisor verified these deficient findings at the time of discovery.	K 372		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 374		9/1/23

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K 374	Continued From page 13 Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell access per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 19.2.2.2.5.2, and 7.2.1.5.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that the keypads located at the both 4th Floor smoke barrior doors used a coded keypad that were mounted higher than the maximum height of 48 inches. 2. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that the keypads located at the both 3rd Floor smoke barrior doors used a coded keypad that were mounted higher than the maximum height of 48 inches.	K 374	Keypads at the smoke barriers are to being remounted below the maximum height of 48 inches. Future keypad work will be below maximum height requirements. Director of Maintenance and/or designee will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition).	

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K 374	Continued From page 14 An interview with the Administrator, the Maintenance Director, and the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 374		
K 522 SS=E	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to keep combustibles clear of heating devices per NFPA 101 (2012 edition), Life Safety Code, section 19.5.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that combustible materials had been placed on and around heating registers in patient room as to not allow air flow and creating a heat transfer hazard in patient rooms: Room 701, Room 703, Room 713, Room 731 and Room 528.	K 522	Register temperature is forced air only created by hot or cold water loops and fan forced no ignition sources in duct work. Rooms have been reorganized. Director of Maintenance and/or designee, (Unit Managers) will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition).	9/1/23

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K 522	Continued From page 15 An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 522		
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have an isolated impact on the residents within the facility.	K 541	Damaged laundry chute door on 5 Gamble repaired 6/28/23 Director of Maintenance and/or designee will monitor and maintain the facility laundry chute doors in order to work	6/28/23

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K 541	Continued From page 16 Finding include On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by observation that the laundry chute door located on the fifth floor was missing the self-closer. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 541	properly and maintain compliance with NFPA 101, (2012 Edition).	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741		9/1/23

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K 741	Continued From page 17 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe place to discard used cigarettes per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/28/2023 at 10:54 AM, it was revealed by observation that there was a large amount of burned discarded cigarettes in the trash can that was in the front entry vestibule. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 741	Smoking burned materials were put into a metal trash bin labeled no smoking materials. Removed bins while Fire Marshal was in area on 6/28/23 Bins where emptied 6/28/23 Bins have been relocated closer to reception desk for monitoring. Director of Maintenance and/or designee, (Receptionist Staff) will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition).	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		9/1/23

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K 761	Continued From page 18 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that the facility could not provide an up-to-date annual fire door inspection report. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 761	Fire doors will be inspected per NFPA 101, (2012 Edition) and documentation has been brought up-to-date. Director of Maintenance and/or designee will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition) for facility fire doors.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 901		9/1/23

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K 901	Continued From page 19 by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that the facility could not provide an NFPA 99 Risk Assessment. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 901	NFPA 99 Risk Assessment to be completed as required in NFPA 101, (2012 Edition). Director of Maintenance and/or designee will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition) for completing the Risk Assessment.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the	K 914		9/1/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 20 electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that the facility could not provide an up-to-date resident room electrical receptacle test report. An interview with the Administrator and the Maintenance Director verified these deficient findings at the time of discovery.	K 914	Complete testing to be completed and required documentation is to be updated and maintained with regard to the maintenance and testing of facility electrical systems. Director of Maintenance and/or designee will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition) for maintenance and testing of electrical systems.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		9/1/23

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**06/28/2023**

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K 918	Continued From page 21 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2.1, 8.4.2.3, 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 918	1. Minimum load on Generator 30% Documentation not available 6/28/23 Documentation found 1000 KW total -minimum normal load 546 kw = 50%+ 6/29/23. 2. Minimum run 4 hours in last 36 months Documentation for 4 hours in the last 36 months Vendor to complete required load bank test as per regulations.	

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K 918	Continued From page 22 1. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey the Maintenance Director was unable to tell me what the size of his generator was, and he did not know what 30% load of his generator was. Since I could not tell what the 30% load of the generator was I was unable to know if he was running the generator at 30% each month, and he did not have an annual load bank completed. 2. On 06/28/2023 between 09:00 AM and 01:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility's Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 918	Director of Maintenance and/or designee will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition) for facility maintenance and testing of essential electric systems.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		9/1/23

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K 920	Continued From page 23 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/28/2023 at 10:09 AM, it was revealed by observation that there was an extension cord being used to plug in a power strip that had portable radios plugged into it near the boiler room door on the lower level. 2. On 06/28/2023 at 11:54 AM, it was revealed by observation that there was an extension cord being used to plug in a fan in the fitness room on the first floor. 3. On 06/28/2023 between 09:21 AM, it was	K 920	1. Radios plugged in to extension cord near boiler room Extension cord was removed 6/28/23 2. Extension cord used to plug in a fan in fitness center Removed extension cord plugged fan directly into outlet and informed staff in the area no extension cords at time of inspection 6/28/23 3. 701 power strip in resident room being used to operate medical device and external arc mark from cell phone charger that had damage from liquid. Power strip was removed at time of discovery. Outlets installed to allow all devices to plug directly into outlets 6/28/23 All items corrected 6/28/23 Director of Maintenance and/or designee will monitor and maintain regulation requirements as indicated in NFPA 101, (2012 Edition).	

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K 920	Continued From page 24 revealed by observation that there was a non-medical grade power strip being used to plug in a medical device, cell phone and a clock/radio in Room 701. This power strip had suffered arcing and shorting damage due to liquids being spilled on outlet. Power strip was taken out of service and removed at time of discovery. An interview with the Administrator, the Maintenance Director, and the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 920	Continuing education of facility staff has occurred in order to report issues and/or to remove power cords/strips that are in violation.	